

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 1/62

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03569 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03562

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lanham</b>		c. LENGTH OF STAY IN b <b>3 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9154 Browns Lane</b>		d. STREET ADDRESS <b>9154 Browns Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Olga Hays Allen</b>		4. DATE OF DEATH <b>March 14th, 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>July 24, 1927</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Typist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otis Lenn Hays</b>		14. MOTHER'S MAIDEN NAME <b>Minnie May Cason</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1949 to 1962</b>		16. SOCIAL SECURITY NO. <b>247-34-9335</b>	
17. INFORMANT <b>Elsie Ruby Thwing, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976X</b> DUE TO <b>Hemorrhage and shock</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Gun shot wound of the head</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Shot self in the head</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY <b>9:15 p.m.</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. INJURY OCCURRED <b>3/14 1962</b>		20f. (City or town) (County) (State) <b>Lanham P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silver Brook Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Anderson, S. Car</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers &amp; Co. Riverdale Md.</b>		24. REC'D BY REGISTRAR <b>Mar 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		DATE	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03570

Items 11 &amp; 12 Film G310 4/2/62 mh

## CERTIFICATE OF DEATH

03563

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>25 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Mt. Rainier</b> d. STREET ADDRESS <b>3271 Queenstown Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) <b>Theresa K. Allen</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28</b> Year <b>19 62</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-17</b>		9. AGE (In years last birthday) <b>45</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b>		11. IF UNDER 24 HRS. Hours <b>18</b> Min. <b>45</b>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>																			
13. FATHER'S NAME <b>James W. Beckert</b>				14. MOTHER'S MAIDEN NAME <b>Sadie Casassa</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Arthur M. Allen, 3271 Queenstown Drive</b>															
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e) <b>199 X</b> DUE TO <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO <b>Carcinoma of es.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Interval between onset and death</b>																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																			
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Mar 3</b> 19 <b>62</b> to <b>Mar 28</b> 19 <b>62</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>3/28</b> 19 <b>62</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.																															
22a. SIGNATURE <b>Samuel J. N. Sugar</b>								22b. DATE <b>SIGNED</b>																							
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR</b>								22d. ADDRESS <b>4637 EASTERN AVE WASH 18, DC</b>																							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/2/62</b>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>																			
24. FUNERAL DIRECTOR'S SIGNATURE <b>St. Hines Co</b>								25a. REC'D BY REGISTRAR <b>2901 145th NW</b>								25b. REGISTRAR'S SIGNATURE <b>DATE MAR 30 '62</b>															

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John Doe

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1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03571

## CERTIFICATE OF DEATH

03564

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>8 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchelville</b> d. STREET ADDRESS <b>Rt. 2 Box 12</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Solomon G. Alston</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-1-12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>
13. FATHER'S NAME <b>Roland Alston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		17. INFORMANT <b>Amy Henry - Mitchelville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, right internal capsule</b> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-3</b> <b>1962</b> , to <b>3-11</b> <b>1962</b> that (I) (we) last saw the deceased alive on <b>3-11</b> <b>1962</b> , and that death occurred at <b>7:30</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>		22b. DATE SIGNED <b>3/12/62</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>6311 Baltimore Ave., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3/15/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Jones Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Mitchelville, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>George H. Kalson Aguasco</b> ADDRESS		25a. REC'D BY REGISTRAR DATE <b>MAR 16 '62</b> 25b. REGISTRAR'S SIGNATURE <b>C. H. E. Evans</b>	

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UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
OFFICE OF THE ASSISTANT ATTORNEY GENERAL  
WASHINGTON, D. C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03572

03565

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>6425 31st Place N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>OMER</u> Middle <u>LEE</u> Last <u>ARBUCKLE</u> <b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>28</u> Year <u>1962</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>4/20/83</u> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Civil Engineer U.S. Government</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>  <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Indiana</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Alexander H. Arbuckle</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Doris V. Hobbs</u> Address <u>same as #2</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>Benign Prostatic Hypertrophy</u> DUE TO (c) <u>ANURIA, GENERALIZED ARTERIO-SCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (If any, list in Part II) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  <b>20f. (City or town)</b> (County) (State)				<b>21. I certify that (I) (the hospital)</b> attended the deceased from <u>11-2-1961</u> to <u>3-28-1962</u> that (I) <del>(we)</del> last saw the deceased alive on <u>3-28-1962</u> and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>David S. Gordon</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>David S. Gordon</u> <b>22b. DATE SIGNED</b> <u>3-28-62</u> <b>22d. ADDRESS</b> <u>5731 23rd PARKWAY SE MD.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u> <b>23b. DATE THEREOF</b> <u>3/31/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Prince Georges County, Md.</u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u> Address <u>2901 14th St. N.W. Washington 9, D.C.</u> <b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 30 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Robert S. Hines</u>			

MEDICAL CERTIFICATION

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE COMPLETED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03573

## CERTIFICATE OF DEATH

Item 2 Film G300 3/23/62 iwl

03566

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 281</u>		d. STREET ADDRESS <u>Box 281</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>VIOLET</u> Last <u>ARNOLD</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1912</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD BROOKS</u>	
14. MOTHER'S MAIDEN NAME <u>MATILDA DOWNS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT Address <u>Box 275</u> <u>Mrs. Dorothy Duckett Bowie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Severe Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Disease - Chronic</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> hrs. <u>Many</u> years <u>  </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>Mar. 8, 1962</u> to <u>Mar. 10, 1962</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 8, 1962</u> to <u>Mar. 10, 1962</u> , that (I) (we) last saw the deceased alive on <u>Mar. 10, 1962</u> , and that death occurred at <u>4A</u> M., from the causes and on the date stated above.		22a. SIGNATURE <u>Henry A. Wise Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>HENRY A. WISE, JR.</u>	
22b. DATE SIGNED <u>  </u>		22d. ADDRESS <u>149 9th St. Bowie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-14-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bowie, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John T. ...</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>  </u>		25c. REGISTRAR'S SIGNATURE <u>  </u>	

VR A15  
15M 7/61

(M)

The 10th of July 1873

My dear Sir

I have the pleasure to inform you that the same has been forwarded to you by the same conveyance as the other papers which I have the honor to acknowledge the receipt of. I am, Sir, very respectfully,  
Yours truly,  
J. H. [Signature]

I am, Sir, very respectfully,  
Yours truly,  
J. H. [Signature]



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03574

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03567

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Roger Heights</b>	
c. LENGTH OF STAY IN b. <b>DOA</b>		d. STREET ADDRESS <b>5014 55th Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATHERINE BERNIECE BAKER</b>	First Middle Last	4. DATE OF DEATH <b>March 24</b>	Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1912</b>
9. AGE (in years last birthday) <b>49</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Comptometer Operator Beauty Supply</b>		11. BIRTHPLACE (State or foreign country) <b>UPPER MERL BORO Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Alexander (n) Moore</b>	
14. MOTHER'S MAIDEN NAME <b>Hattie M. Ryon</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>577-245837</b>		17. INFORMANT <b>Harry C. Baker 5014 55th Ave., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Congestion &amp; Edema</b>			
Conditions, if any, which gave rise to immediate cause (b) <b>Gloma of left frontal lobe of brain.</b>			
(a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <b>While at work</b> 20d. INJURY OCCURRED <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3/24/62</b>			
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>3-28-62</b> 22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATL CEM</b> 22d. LOCATION (City, town, or country) (State) <b>SUITLAND MD</b>			
23. FUNERAL DIRECTOR <b>W.W. Chambers</b> ADDRESS <b>517-11th St SE</b> 24a. REC'D BY REGISTRAR <b>MAR 29 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

MEDICAL CERTIFICATION

2

2



1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03575

CERTIFICATE OF DEATH

Item 7 Film GSC-3-1752 iwx

03568

1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

So. America

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN

11 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Maracaibo, Venezuela

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince Georges General Hospital

d. STREET ADDRESS

Superior Oil Co.  
Apartado 168

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

ALMER

W

BEALE

4. DATE OF DEATH

Month

Day

Year

March

19

19 62

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

27 Nov. 1913

9. AGE (in years last birthday)

48 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Superintendent

10b. KIND OF BUSINESS OR INDUSTRY

Marine - Oil Co. Maine

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Almer W. Beale

14. MOTHER'S MAIDEN NAME

Verna Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes

WW II

16. SOCIAL SECURITY NO

17. INFORMANT

Address

Emily Beale, 4900 Cherokee St.

College Park, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

INTERVAL BETWEEN ONSET AND DEATH

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 6, 1962, to March 19, 1962 that (I) (we) last saw the deceased alive on March 19, 1962, and that death occurred at 3:00AM from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

3/19/62

22d. ADDRESS

College Park, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)

Burial

3-22-1962

23c. NAME OF CEMETERY OR CREMATORY

Arlington Nat'l. Cemetery, Arlington, Va.

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Joseph G. Gwin's Sons 1756 Pa. Ave. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR

DATE MAR 22 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas









HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03577

03570

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Carrollton</b> d. STREET ADDRESS <b>6402 - 85th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Garfield Berry</b>		4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-27-82</b>	
9. AGE (In years last birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>8</b>	
11. IF UNDER 24 HRS. Hours <b>8</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emory Berry</b>		14. MOTHER'S MAIDEN NAME <b>(unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hattie P. Berry 6402 85th Pl. Carrollton, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary heart failure</b> <b>Diabetic mellitus</b> <b>Generalized atherosclerosis</b> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>3 weeks</b> <b>5 yrs</b> <b>5 yrs</b> <b>5 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)	
20h. (State)		20i. (Country)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 Feb 1962</b> to <b>8 Mar 1962</b> that (I) (we) last saw the deceased alive on <b>7 Mar 1962</b> and that death occurred at <b>4:55 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John Kehoe</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>		22b. DATE SIGNED <b>1835 Eye Street, N.W., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-12-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City, town or county) <b>Washington, D.C.</b>	
23e. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>		23f. REGISTRAR'S SIGNATURE <b>DATE MAR 13 '62</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03578

CERTIFICATE OF DEATH

03571

1. PLACE OF DEATH a. COUNTY <i>Pr Geo</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pr Geo</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pr Geo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4807 - Treadway St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>GERSON</i> First <i>P</i> Middle <i>BICKFORD</i> Last		4. DATE OF DEATH <i>Mar 20 1962</i> Month <i>Mar</i> Day <i>20</i> Year <i>1962</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 15, 1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Aathan Bickford</i>		14. MOTHER'S MAIDEN NAME <i>Arabelle Cohn</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>none</i>	
17. INFORMANT <i>Aurelia E Bickford</i> Address <i>College Park, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Ac Congestive Heart Failure</i> <i>4-34-1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>20</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Bronchopneumonia, Left Lower</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>3/4</i> to <i>3/20 62</i> that (I) (we) last saw the deceased alive on <i>3/15 62</i> and that death occurred at <i>11:55</i> A. M. from the causes and on the date stated above			
22a. SIGNATURE <i>W. C. Etienne</i> M D		22b. DATE SIGNED <i>3/20/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		22d. ADDRESS <i>College Park, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar 23, 1962</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington D C</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i> ADDRESS <i>Hyattsville, Md.</i>		25a. REC'D BY REGISTRAR <i>DATE MAR 27 '62</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Pinner</i>	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03579

Item 13 Inf. from birth certificate

03572

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>10 hr</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>31 Fairmont Heights</b> d. STREET ADDRESS <b>5709 J Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl Blackwell</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>17 March 1962</b>	
9. AGE (In years last birthday) Years <b>10</b> Months <b>10</b> Days <b>10</b>		10. AGE (In years last birthday) Years <b>10</b> Months <b>10</b> Days <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Robert Blackwell</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Romaine Holden</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity (2 lbs 12 oz)</b> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Atletasis</b> (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-17</b> <b>19 62</b> to <b>3-18</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>3-18</b> <b>1962</b> , and that death occurred at <b>12:05 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas A. Christensen MD</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>			
22b. DATE SIGNED <b>3/19/62</b>			
22d. ADDRESS <b>6905 Baltimore Ave., College Park, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			
23b. DATE THEREOF <b>3-31-62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>			
23d. LOCATION (City, town or county) (State) <b>Cheverly, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b> <b>2-045932</b>			
25a. REC'D BY REGISTRAR <b>DATE APR 2 1962</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>			

Harry W. Penn, Jr., Administrator

2-045932





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03573

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>4002 38th., Street</b>	
3. NAME OF DECEASED (Type or print) <b>Ida Eva Elizabeth Bowen</b>		4. DATE OF DEATH <b>March 7, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois Quincy</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benjamin Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Louisa Weisenburger</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>		16. SOCIAL SECURITY NO. <b>16-111111111</b>	
17. INFORMANT <b>Nell Louise Bowen, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cardiovascular renal disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <b>Carcinoma of the liver</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. _____	Month, Day, Year ____/____/____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <b>3/9/62</b>		DATE SIGNED <b>3/7/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or country) <b>Colmar Manor, Md.</b>	
22e. ADDRESS <b>mt Rainier</b>		22f. (State) _____	
23. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 12 '62</b>	
24b. REGISTRAR'S SIGNATURE _____		24c. _____	



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03575

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if not at one residence before admission)  
a. STATE b. COUNTY

Washington

D.C.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN IL

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Temple Hills

3 days

Washington, DC

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

6431 Gull Road

1116 K St., N.E.

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

KALMAN

(N)

BRETLER

March 24

1962

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS.)

Male

White

WIDOWED ☒

DIVORCED ☐

July 10, 1883

78 yrs

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Retired

Grocery Store Owner

Austria

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

UNKNOWN

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO. 17. INFORMANT

Address

No

Unknown Leah B. Biller

2410 N. Randolph St., Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Coronary artery disease

Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m., p.m.

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James J. Boyd

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

JAMES I. BOYD

Address (Street, city, town, or county)

3/24/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

Burial

3-26-62

National Capital Hebrew Cem.

Washington, DC

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Bernard Danzansky & Sons

3501 14th St. NW

MAR 27 '62

Arthur S. Hanks

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 115 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03582 CERTIFICATE OF DEATH 03576

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Georges c. LENGTH OF STAY IN b 7 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 305 - 67th. Place	
3. NAME OF DECEASED (Type or print) John I. Brickerd First Middle Last		4. DATE OF DEATH March 16 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-13-92 Last
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY 7-13-1918-3-22-1919 D.C.	
13. FATHER'S NAME DENNIS BRICKERD		14. MOTHER'S MAIDEN NAME MARY HURLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 7-13-1918-3-22-1919		16. SOCIAL SECURITY NO. 577-01-6907A	
17. INFORMANT Mary Rooney		18. ADDRESS 6000 Millaw Dr Seat Pleasant Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4 20.0 IMMEDIATE CAUSE (a) Congestive Heart Failure (b) Anterior wall Heart Disease (c) DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-12-62, 1962 to 3-18-62, 1962 that (I) (we) last saw the deceased alive on 3-18-62, 1962, and that death occurred at 10:10 P.M. on the causes and on the date stated above.			
22a. SIGNATURE George William Ware		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. George W. Ware		22d. ADDRESS 1835 Eye St., N. W., Washington 6, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cmt		23d. LOCATION (City, town, or county) (State) Arlington VA	
24. FUNERAL DIRECTOR'S SIGNATURE J.W. Lee - Wash. D.C.		25a. REC'D BY REGISTRAR DATE MAR 22 '62	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	





UNITED STATES DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03583

03577

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>OKLAHOMA</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE, MD.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE McMann</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL</b>		d. STREET ADDRESS <b>/CAMP/SPRINGS/ Box 328</b>	
3. NAME OF DECEASED (Type or print) First <b>WARREN</b> Middle <b>RAY</b> Last <b>BROCKETT</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 17, 1940</b>
9. AGE (In years last birthday) <b>21</b> yrs		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AIRMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US AIR FORCE</b>	
11. BIRTHPLACE (State or foreign country) <b>MAUD, OKLAHOMA</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JOE B BROCKETT</b>		14. MOTHER'S MAIDEN NAME <b>LAVURN STRICKLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>1959 - 1962</b>		16. SOCIAL SECURITY NO. <b>1959 - 1962</b>	
17. INFORMANT <b>FATHER</b>		Address <b>BOX 328, MCMANN, OKLAHOMA</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBELLAR TONSILLAR HERNIATION</b> <b>↑ 02.8</b> DUE TO <b>CEREBRAL EDEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO <b>CONCUSSION</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE DISLOCATION C5 - C6, SPINAL CORD COMPRESSION; SUBARACHNOID</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>FELL OFF OF POWER POLE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>HEMORRHAGE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7:30</b> p.m. <b>MAR 6 1962</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ANDREWS AFB PRINCE GEORGES MD</b>		20f. (City or town) (County) (State)	
21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>6 MAR 1962</b> , to <b>9 MAR 1962</b> , that <b>XX</b> (we) last saw the deceased alive on <b>9 MAR 1962</b> , and that death occurred at <b>10:15 A</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Gerald Schuster</b>		22b. DATE SIGNED <b>9 MARCH 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>GERALD SCHUSTER, Capt USAF MC</b>		22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>SHIP RA</b>	23b. DATE THEREOF <b>3-11-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Seminole Oklahoma</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers G 517-110 St SE.</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>C. H. G. G. G.</b>			







CERTIFICATE OF DEATH

03585

03579

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home, Inc.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>7310 Insey St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary E. Brooks</u> First Middle Last <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9/1/83</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>78</u> yrs <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>DATE OF DEATH</b> <u>March 30, 1962</u> Month Day Year	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>CSS. Commission</u> <b>11. BIRTHPLACE</b> <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>		<b>13. FATHER'S NAME</b> <u>Thomas Oaden</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO</b> <u>W.M. Brooks, 7310 Insey St., Dist. Hts</u> <b>17. INFORMANT</b> <u>Interval between onset and death</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolism</u> (b) <u>Hypertensive arteriosclerosis</u> (c) <u>Chronic Cerebro-Vascular disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause est. <u>45 MINS. 6-8 YRS. 3-4 M/O</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1953</u> <b>20d. INJURY OCCURRED</b> <u>1953</u> Hour a.m. p.m. <u>19</u> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office b.d.g., etc.) <u>7200 MARLBORO PIKE S.E.</u> <b>20f. (City or town)</b> <u>Suitland, Md</u> <b>(County)</b> <u>Prince Georges</u> <b>(State)</b> <u>Md</u>			
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>1953</u> <b>to</b> <u>MARCH 30, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>3/30/62</u> <b>and that death occurred at</b> <u>5:15 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Sidney W. Lowry</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>SIDNEY W. LOWRY</u>		<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <u>7200 MARLBORO PIKE S.E.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>4-2-62</u> <b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u> <b>23d. LOCATION</b> (City, town or county) <u>Suitland, Md</u> <b>(State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. LEE</u> <b>25a. REC'D BY REGISTRAR</b> <u>APR 6 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>25c. ADDRESS</b> <u>300 4 ST N.E.</u>	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



03586

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03580

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 2, should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. If the FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>Rural Route Box # 1323</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Brown</b>		4. DATE OF DEATH <b>March 3 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1918</b>
9. AGE (In years last birthday) <b>43 yrs.</b>		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Manes Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mady Harrison</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Betty Brown</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <b>120.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/9/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Ceme.</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>Charles E. Stewart</b>		Address <b>40 H Street, N.E. D.C.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Charles E. Stewart</b>	
DATE <b>MAR 12 '62</b>			





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03587  
03581  
CERTIFICATE OF DEATH

**1. PLACE OF DEATH**  
a. COUNTY **Prince Georges** **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Landover**  
c. LENGTH OF STAY IN b **10 Mos.**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Largo Road**

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)  
a. STATE **Maryland** b. COUNTY **Pr. Geo's**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Upper Marlboro**  
d. STREET ADDRESS **---**

**3. NAME OF DECEASED** (Type or print) **James Alfred Bryan**  
First Middle Last

**4. DATE OF DEATH** **MAR 11 1962**  
Month Day Year

**5. SEX** **Male** **6. COLOR OR RACE** **White** **7. MARRIED** ☒ **NEVER MARRIED** ☐ **8. DATE OF BIRTH** **Aug. 19, 1881**  
**9. AGE** (In years, last birthday) **80 yrs.** **IF UNDER 1 YEAR** **IF UNDER 24 HRS.**  
Months Days Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) **Tobacco Farming** **10b. KIND OF BUSINESS OR INDUSTRY** **Tenant** **11. BIRTHPLACE** (County & State, or foreign country) **Maryland** **12. CITIZEN OF WHAT COUNTRY?** **U. S. A.**

**13. FATHER'S NAME** **Unknown** **14. MOTHER'S MAIDEN NAME** **Margaret (nee Bryan)**  
Address

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service) **Unknown** **16. SOCIAL SECURITY NO** **17. INFORMANT** **James Alonzo Bryan--Landover, Md.**  
Address

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **4 + 20 yrs** **Coronary Heart Failure** **INTERVAL BETWEEN ONSET AND DEATH** **3 yrs**  
Conditions, if any, which gave rise to immediate cause (b) **Atherosclerotic Coronary Artery Disease** **15 yrs**  
(a), stating the underlying cause last. (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

**19. WAS AUTOPSY PERFORMED?** **YES** ☐ **NO** ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)  
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20c. TIME OF INJURY** Month, Day, Year **19** **20d. INJURY OCCURRED** **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

**21. I certify that (I) (this hospital) attended the deceased from** **June 1950**, to **MAR 11 1962**, that (I) (we) last saw the deceased alive on **1 MAR 1962**, and that death occurred at **7:40 PM**, from the causes and on the date stated above.

**22a. SIGNATURE** **Robert B. Sasscer, M.D.** **22b. DATE SIGNED** **3/11/62**  
M.D. **22c. PHYSICIAN'S NAME (Type)** **Robert B. Sasscer, M.D.** **22d. ADDRESS** **Upper Marlboro, Maryland.**

**23a. BURIAL, CREMATION, REMOVAL (Specify)** **Burial** **23b. DATE THEREOF** **3/15/62** **23c. NAME OF CEMETERY OR CREMATORY** **Holy Rosary Cemetery** **23d. LOCATION (City, town or county)** **Rosaryville Md.** (State)

**24. FUNERAL DIRECTOR'S SIGNATURE** **Ritchie Bros. Fun'l Home-Upper Marlboro** **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE** **Carlton L. Pinner**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 4 and file it with the State Dept. of Health.



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 103582  
03588  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Kentucky b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Louisville	
c. LENGTH OF STAY IN 1b Transient		d. STREET ADDRESS 3328 Illinois Ave.,	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 197		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence J. Bryant		4. DATE OF DEATH March 7th, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1914
9. AGE (In years last birthday) 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Groom	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Bryant		14. MOTHER'S MAIDEN NAME Dora Willoughby	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 11		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT GODFREY F. RUSSMAN		Address 1041 Goss Ave Louisville, KY.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of skull & left knee crushed chest & fracture of left clavicle Conditions, if any, which gave rise to immediate cause (b) (c) (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of automobile that ran off road	
20c. TIME OF INJURY Month, Day, Year Hour 9:40 p.m. Mar 7 1962		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 197 Laurel P.G. Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-1962	
22c. NAME OF CEMETERY OR CREMATORY Cave Hill Cemetery		22d. LOCATION (City, town, or country) Louisville, Kentucky	
23. FUNERAL DIRECTOR W.W. Chambers & Co. Riverdale, Md.		24a. REC'D BY REGISTRAR MAR 14 '62	
		24b. REGISTRAR'S SIGNATURE C. S. Harris	

MEDICAL CERTIFICATION

2.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

03589  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03583

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Takoma Park</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1003 Hopewell Avenue</b>				d. STREET ADDRESS <b>1003 Hopewell Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Wyman</b> Last <b>Campbell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 62</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/12/ 1948</b>	
9. AGE (In years last birthday) <b>13</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Clyde B. Campbell</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Howe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>Clyde B. Campbell</b> Address <b>1003 Hopewell Avenue Takoma Park, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Retrospectival Malignancy</b> <b>158X</b> DUE TO <b>Diagnosis of other cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>6 Mo</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>March 14, 1962</b> to <b>March 15, 1962</b> that (I) <del>was</del> last saw the deceased alive on <b>March 14, 1962</b> and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold Hedges</b> M. D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>3/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Harold Hedges</b>				22d. ADDRESS <b>1835 Eye St N.W. DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>3/19/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>				25a. REC'D BY REGISTRAR <b>DATE MAR 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>in Hines</b>	
Washington, D.C. <b>(10 vet)</b>							

Donald Thompson MD

Boy has been under care of Robert  
Bosworth, MD whilst a patient Sibley House.

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

77

(I)

MEDICAL CERTIFICATION

MARYLAND AND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
03591											
03585											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Huntsville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General				d. STREET ADDRESS 1101 70th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) James				First Middle Last James Coates				4. DATE OF DEATH 3-18-1962			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown		9. AGE (in years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Augustine Queen 7273 Kolb Street, N.E.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4918 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from. 3-17....., 1962 to.....3-18....., 1962, that (I) (we) last saw the deceased alive on 3-18.....1962, and that death occurred at P.M., from the causes and on the date stated above.											
22a. SIGNATURE David S. Clayman				22b. DATE SIGNED 3/19/62				22c. PHYSICIAN'S NAME (Type) Dr. David S. Clayman			
22d. ADDRESS 6311 Ba Ho Ave Riverdale, Md.				22e. DATE MAR 21 '62							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/16/62				23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery			
23d. LOCATION (City, town or county) Washington, D.C.				23e. REC'D BY REGISTRAR DATE							
24. FUNERAL DIRECTOR'S SIGNATURE Blair G. Stewart				24b. ADDRESS 30 H Street, N.E.				25b. REGISTRAR'S SIGNATURE Curtis S. Kinn			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbons, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03582

Item 13 **CERTIFICATE OF DEATH**

03586

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN IL <b>2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Coborn</b>		6237 64 Ave		4. DATE OF DEATH Month Day Year <b>March 25 1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23 1962</b>		9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Chester Henry Coborn</b>				14. MOTHER'S MAIDEN NAME <b>Carol Jean Larson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>				16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mother</b> Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <b>542</b> DUE TO <b>1. Bilateral Pulmonary</b> <b>2. Congenital Heart Disease (Ventricular septal)</b> <b>3. Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Atelectasis</b> (c) <b>Coronary Artery Disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/23</b> , 1962 to <b>3-25</b> , 1962, that (I) (we) last saw the deceased alive on <b>3-25</b> , 1962, and that death occurred at <b>12:40</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John W. Perkins</b>				22b. DATE SIGNED <b>3/25/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. John W. Perkins</b>	
22d. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Perkins Jr., Administrator</b>				25a. REC'D BY REGISTRAR <b>APR 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03593 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03587

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A.  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street and address) Prince George's General Hospital  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ xx

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)  
a. STATE Maryland b. COUNTY Prince George's  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville  
d. STREET ADDRESS Route # 2

3. NAME OF DECEASED (Type or print) First Middle Last  
Sylvester Nathaniel Coleman  
4. DATE OF DEATH Month Day Year  
March 10 19 62

5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH  
March 5, 1940 9. AGE (In years last birthday) 22 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Food 11. BIRTHPLACE (State or foreign country) District of Columbia U. S. A.  
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Nathaniel Coleman 14. MOTHER'S MAIDEN NAME Elizabeth Gertrude Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. 214-36-2861 17. INFORMANT Elizabeth G. Warner, same as # 2 Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock  
(b) LACERATION OF AORTA  
(c) DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. Head on automobile collision  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month Day Year 1:49 a.m. 3/10/1962 20d. INJURY OCCURRED While at work ☒ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road 20f. (City or town) (County) (State) Bowie P. G. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) James I. Boyd ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ 3/10/62  
Address (Street, city, town, or county) Woodmore Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 3-14-62 22c. NAME OF CEMETERY OR CREMATORY Holy Family 22d. LOCATION (City, town, or country) (State) Woodmore Md.

23. FUNERAL DIRECTOR Henry Washington Sur 4925 Dean Ave NE ADDRESS 24a. REC'D BY REG STRAR 24b. REGISTRAR'S SIGNATURE  
MAR 15 '62 Charles L. Hanna



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03594

03588

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> c. LENGTH OF STAY IN b. <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1000 Daleview Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DORA REAVILL COOK</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>19 62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/7/1869</u>	
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. FATHER'S NAME <u>Andrew J. Reavill</u>		14. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Harold T Cook</u>		18. ADDRESS <u>Washington D C</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> DUE TO <u>Coronary thrombosis</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>4 hours</u> <u>none</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1962</u> to <u>3-13-62</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3-13-62</u> and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Donald C. Edgeman</u>		22b. DATE SIGNED <u>3-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGEMAN</u>		22d. ADDRESS <u>HYATTSVILLE, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/16/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City, town or county) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>Hyattsville, Maryland</u> DATE <u>MAR 19 '62</u>			





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03595

## CERTIFICATE OF DEATH

03589

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>30 years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5512 43rd Place</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>63 Hyattsville,</b> d. STREET ADDRESS <b>5512 43rd Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARGARET</b> First Middle Last 4. DATE OF DEATH <b>March 15, 1962</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Feb. 8, 1876</b> 9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (Country & State, or foreign country) <b>England</b> 12. CITIZEN OF WHAT COUNTRY? <b>England</b>		13. FATHER'S NAME <b>John Cullen</b> 14. MOTHER'S MAIDEN NAME <b>Mary McPartlan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b> 16. SOCIAL SECURITY NO. <b>none</b> 17. INFORMANT <b>Austin J. Cullen same as #2 (Brother)</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>arterial Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary thrombosis</b> (c) <b>arteriosclerotic Heart Disease</b> DUE TO cause last, <b>arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>11</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>1958 to 3-15, 1962</b> that (I) (we) last saw the deceased alive on <b>3-15, 1962</b> and that death occurred at <b>11 A.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Donald C. Edgren</b> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b> 22d. ADDRESS <b>Hyattsville, Md.</b> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/19/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b> 23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b> 25a. REC'D BY REGISTRAR <b>MAR 19 1962</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cause of death, and in any event, within 72 hours after death. be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03597

CERTIFICATE OF DEATH

Reg. Dist. No. 03591

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Henry</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1962</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1916</u>	9. AGE (In years last birthday) yrs. <u>45</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>Frederick Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Gilberta Slater - Brandywine, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>None</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>March 17, 1962</u> , to <u>March 17, 1962</u> , that I last saw the deceased alive on <u>March 17, 1962</u> , and that death occurred at <u>2:50</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Nelson</u> M.D.				DATE SIGNED <u>March 22, 1962</u>			
22. NAME (Type) <u>George H. Nelson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas</u>		22d. LOCATION (City, town, or county) (State) <u>Aquasco, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Nelson</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 is to be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A:JME  
5M 1/62

MEDICAL CERTIFICATION

03598  
03592  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale D.O.A.  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if last full year; Residence before admission)  
a. STATE Massachusetts  
b. COUNTY  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Jamaica Plains  
d. STREET ADDRESS 3302 Washington Street  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Francis William Donald  
4. DATE OF DEATH March 7th., 1962  
5. SEX Male  
6. COLOR OR RACE White  
7. MARRIED ☐ NEVER MARRIED ☒  
8. DATE OF BIRTH May 18th., 1922 39 yrs.  
9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exercise Boy  
10b. KIND OF BUSINESS OR INDUSTRY Race Track  
11. BIRTHPLACE (State or foreign country) Mass.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Alexander Donald  
14. MOTHER'S MAIDEN NAME Ola Beatrice Ready  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11  
16. SOCIAL SECURITY NO. Unknown  
17. INFORMANT Mrs. Vivian Black 170 L Street, So. Boston, Mass.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture of skull & left knee  
Conditions, if any, which gave rise to immediate cause (b)   
(c)   
(e), stating the underlying cause last.   
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)   
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.   
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in automobile that ran off road  
20c. TIME OF INJURY Month, Day, Year 9:40 p.m. Mar. 7, 1962  
20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒  
20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.) Route 197 Laurel P.G. Md.  
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James L. Boyd M.D.  
EXAMINER'S NAME (Type) JAMES L. BOYD, M.D.  
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
22b. DATE THEREOF 3-14-1962  
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL  
22d. LOCATION (City, town, or country) (State) ARLINGTON, VIRGINIA  
23. FUNERAL DIRECTOR Will Chambers Co. Riverdale, Md.  
24a. REC'D BY REGISTRAR  
24b. REGISTRAR'S SIGNATURE  
DATE MAR 15 '62

DATE SIGNED  
3/8/62

W. L. S. House





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																																		
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																																		
CERTIFICATE OF DEATH																																		
02599					Items 11 & 12 from 0309 3/15/62 iwk					03593																								
1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>01 Laurel</b> d. STREET ADDRESS <b>103 Main Street</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) <b>James</b>					4. DATE OF DEATH <b>Dorsey</b> <b>March 2 19 62</b>																													
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>About 1883</b>					9. AGE (in years last birthday) <b>79 7 yrs.</b>					10. IF UNDER 1 YEAR Months Days Hours Min.					11. IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Groom</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Race Horse Track</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Unknown Ireland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																			
13. FATHER'S NAME <b>Patrick Dorsey</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown</b>					16. SOCIAL SECURITY NO. <b>Unknown</b>					17. INFORMANT <b>Hosp.</b>					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>CVA = Cerebral vascular accident</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>																								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) <b>Baltimore</b>					(County) <b>Baltimore</b>					(State) <b>Md.</b>									
21. I certify that (I) (this hospital) attended the deceased from... <b>Feb. 25</b> ....., 19 <b>62</b> to... <b>March 2</b> ....., 19 <b>62</b> , that (I) (we) last saw the deceased alive on... <b>March 2</b> ....., 19 <b>62</b> , and that death occurred at... <b>2:25 A.M.</b> from the causes and on the date stated above.					22a. SIGNATURE <b>Dr. Albert Roth</b> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED <b>3/8/62</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>3/8/62</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>					23d. LOCATION (City, town or county) <b>Baltimore, Md.</b>					(State) <b>Md.</b>														
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. Vernon Lemmon</b>					ADDRESS <b>4611 Park Heights, Balto.</b>					25a. REC'D BY REGISTRAR <b>MAR 8 '62</b>					25b. REGISTRAR'S SIGNATURE <b>C. J. S. Finner</b>																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN 1b <u>8 yrs</u> d. NAME OF HOSPITAL OR INST. TUT. ON (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>28 Arondale St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>a</u> Middle <u>DOVET</u> Last 4. DATE OF DEATH <u>Mar 20</u> 19 <u>62</u> 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 13, 1915</u> 9. AGE (In years last birthday) <u>46</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RACE TRACK</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HORSE GROOM</u> 11. BIRTHPLACE (County & State or foreign country) <u>St. Louis, Missouri</u> 12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>			
13. FATHER'S NAME <u>JOSEPH DOVET</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>401-19-0553</u> 17. INFORMANT <u>BLANCHE DOVE</u> Address <u>28 Arondale St, Laurel</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>163X</u> (c) <u>163X</u> DUE TO cause stating the underlying cause last (c) <u>163X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER!) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>2/26</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>61</u> to <u>3/20</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/20</u> , 19 <u>62</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B. P. Warren</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3/20</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. P. Warren</u> 22d. ADDRESS <u>Laurel MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF <u>Burial 3/23/62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ory Hill</u> 23d. LOCATION (City, town or county) (State) <u>Laurel MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u> ADDRESS <u>5024 47th St Laurel MD</u> 25a. REC'D BY REGISTRAR <u>3/28/62</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u>			



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03601 CERTIFICATE OF DEATH 03595

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belmont Memorial Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u> d. STREET ADDRESS <u>6104 A Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Alva Louise Dowell</u> First Middle Last <b>4. DATE OF DEATH</b> <u>March 21 1962</u> Month Day Year		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-12-17</u> <u>44</u> yrs. <b>9. AGE</b> (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR, Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Maurice Milburn</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sallie Dove</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <b>16. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO (b) <u>Cardiac Decomp / Lobar Pneumonia</u> DUE TO (c) <u>Pelvic Peritonitis - Ruptured Left Fallopian Tube</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, 16. <u>Hospital Record</u>		<b>17. INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 minutes</u> <u>2 days</u> <u>7 days</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.) <b>20c. TIME OF INJURY</b> Hour <u>19</u> Month, Day, Year <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town, (County) (State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>15 March 1962</u> <b>to</b> <u>21 March 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>21 March 1962</u> <b>and that death occurred at</b> <u>3 P.M.</u> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>Thomas M. Hutchins</u> <b>M.D.</b> <b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>THOMAS M. HUTCHINS</u> <b>22b. DATE SIGNED</b> <u>3-21-62</u> <b>22d. ADDRESS</b> <u>7315 Landonover Rd Hyattsville, Md</u>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>23b. DATE THEREOF</b> <u>3-26-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>CEDAR HILL CEM</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>SUITLAND MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Shaver</u> <b>ADDRESS</b> <u>Reverend St. Paul</u> <b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Shaver</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Shaver</u> <b>DATE</b> <u>MAR 27 '62</u>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/62

03602  
MARYLAND STATE DEPARTMENT OF HEALTH  
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03596

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN TOWN <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> d. STREET ADDRESS <b>8th and Maple Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Dwayne</b> Middle <b>Michael</b> Last <b>Duckett</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 9, 1961</b>	
9. AGE (In years last birthday) <b>3</b> yrs. <b>3</b> months <b>2</b> days		10. IF UNDER 1 YEAR <b>3</b> yrs. <b>3</b> months <b>2</b> days	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ivory Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Duckett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Evelyn Duckett, same as # 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 493X Conditions, if any, which gave rise to immediate cause (b) <b>DUE TO</b> (c) <b>DUE TO</b> (a), stating the underlying cause last. <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3/11/62</b>			
Address (Street, city, town or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
22b. DATE THEREOF <b>3-15-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. CEMETERY SUITLAND, MD</b>			
22d. LOCATION (City, town, or country) <b>3015-12th St. N.E. D.C.</b>			
23. FUNERAL DIRECTOR <b>John T. Rhines &amp; Co.</b>			
24a. REC'D BY REGISTRAR <b>3/15/62</b>			
24b. REGISTRAR'S SIGNATURE <b>William S. Rhines</b>			

MEDICAL CERTIFICATION

2

23. FUNERAL DIRECTOR

**John T. Rhines & Co. 3015-12th St. N.E. D.C.**

**1-1-1-31P**





CERTIFICATE OF DEATH

Reg. Dist. No. 03597

03603

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY			
b. C.ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hasbrouck Heights</u>		67X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suitland Nursing Home</u>				d. STREET ADDRESS <u>257 Walton Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Eckert</u> Last <u>Felder</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>19 62</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/1874</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Eckenfelder</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Meyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>S. Thomson Eckenfelder Washington 27, D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 5, 1962</u> to <u>May 9, 1962</u> , that I last saw the deceased alive on <u>May 9, 1962</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. N. Thibadeau</u> M.D.				DATE SIGNED <u>3/12/62</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Thibadeau</u>				ADDRESS (Street, city or town, state) <u>Washington 27, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASHINGTON MEM. PK</u>		22d. LOCATION (City, town, or county) (State) <u>PARAMUS, NEW JERSEY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Early</u>				ADDRESS <u>Pyndole Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. S. King</u>			



1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03604 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03598

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Riverdale  
c. LENGTH OF STAY IN Ib D.O.A.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)  
a. STATE Maryland b. COUNTY Prince George's  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, Mobile Homes  
d. STREET ADDRESS 4 5th Street

3. NAME OF DECEASED (Type or print) First Middle Last  
Louis John Ehrler  
4. DATE OF DEATH Month Day Year  
March 20 19 62

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH Aug. 31, 1903  
9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman 10b. KIND OF BUSINESS OR INDUSTRY U. S. Government Missouri  
11. BIRTHPLACE (State or foreign country) U. S. A.  
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Louis J. Ehrler 14. MOTHER'S MAIDEN NAME Lottie UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Etna Marie Esrich, Washington D.C.  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
(a) IMMEDIATE CAUSE (e) Acute congestive heart failure  
(b) Myocardosis  
(c) DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Cirrhosis of the liver

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd  
EXAMINER'S NAME (Type) James I. Boyd  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒  
DATE SIGNED 3/20/62  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 3-23-62 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem - 22d. LOCATION City, town, or country (State) Suitland Maryland  
23. FUNERAL DIRECTOR W. W. Chamber Co Riverdale, Maryland 24e. REC'D BY REG. STRAR 24f. REGISTRAR'S SIGNATURE  
MAR 23 '62 Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 is to be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR 15ME  
SM 1/62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03605

03599

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eugene Leland Memorial</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>15 Riverdale</u> d. STREET ADDRESS <u>4811 Riverdale Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth M. Eshelbrenner</u>		4. DATE OF DEATH <u>March 24 1962</u>	
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 10, 1877</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George Humphreville</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Glazier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Robert E. Eshelbrenner Same as #2 (son)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY ARTERIO-SCLEROTIC HEART DISEASE 10 yrs.</u> (a), stating the underlying cause last (c) <u>CHRONIC CONGESTIVE HEART FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from. ... 19 <u>57</u> to ... <u>3-23-</u> 19 <u>62</u> , that (I) <u>was</u> last saw the deceased alive on <u>3-23-</u> 19 <u>62</u> and that death occurred at <u>8:15 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Elbert H. Noel, MD</u>		22b. DATE SIGNED <u>3/24/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>5500 Madison St. Riverdale, Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/28/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town or county) (State) <u>Lancaster Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1962</u>	
ADDRESS <u>Hyattsville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03600

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTYPrince George's MARYLAND  
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)  
Cheverly DOA  
c. LENGTH OF STAY IN b.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

3. NAME OF  
DECEASED  
(Type or print)

5. SEX

Male

Guy

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐DIVORCED ☐

8. DATE OF BIRTH

December 25, 78

9. AGE (In years last birthday)

83 yrs.

F UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Insurance agent

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Samuel Farson

14. MOTHER'S MAIDEN NAME

Isabelle Virginia Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO

5-7705-7011a

17. INFORMANT

Mrs Elsie A. Martin, Baltimore, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

Cerebrovascular accident

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last

DUE TO

Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Hour a.m.  
p.m.Month, Day, Year  
1920d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

SIGNATURE

EXAMINER'S  
NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

March 25, 1962

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/28/62

22c. NAME OF CEMETERY OR CREMATORY

Mt. Olivet Cemetery

22d. LOCATION (City, town, or country)

Baltimore, Md.

23. FUNERAL DIRECTOR

Valley's Funeral Home Inc.

ADDRESS

Mt. Rainier Md.

24a. REC'D BY REG. STRAR

DATE MAR 30 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Haines

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03607 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03601

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>Home Park 6 Pine Lane, Pflisters Mobile</b>	
3. NAME OF DECEASED (Type or print) <b>Albert Herman Fenrich</b>		4. DATE OF DEATH <b>March 1, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1905, 36</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Fenrich</b>		14. MOTHER'S M.A.D.E.N NAME <b>Marie Lubenow</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>473-09-9034</b>	
17. INFORMANT <b>Eleanor Katherine Fenrich, same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary artery disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/7/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCAT ON (City, town, or country) (State) <b>Bartonsville Md.</b>	
23. FUNERAL DIRECTOR <b>De Witt Canabrown, Laurel Md</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 7 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Cassius E. Krause</b>			

MEDICAL CERTIFICATION



TO HOSPITAL ☐ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

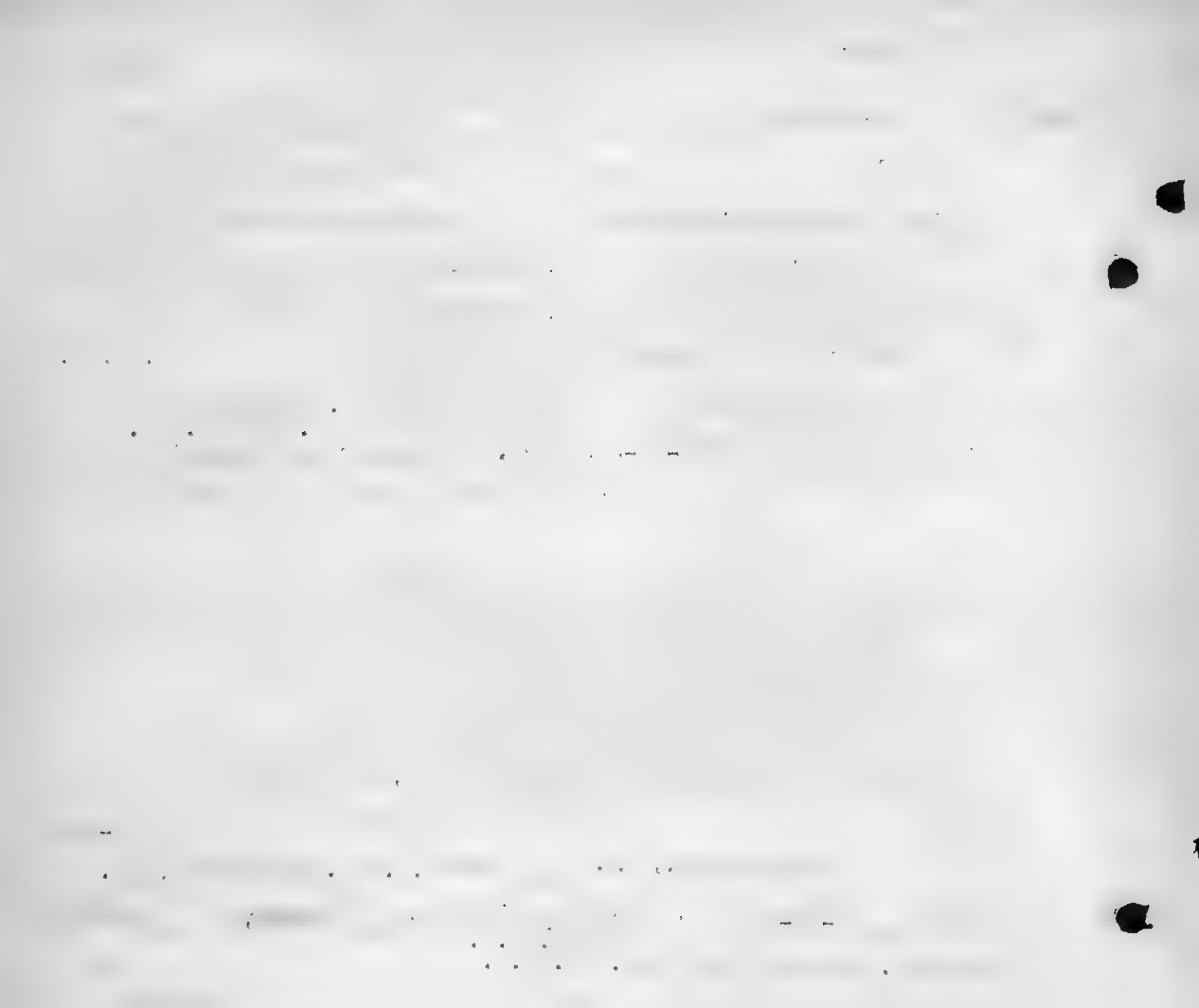
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03608

CERTIFICATE OF DEATH

03602

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> d. STREET ADDRESS <b>8402 Manchester Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Geraldine M Fiteg</b> 4. DATE OF DEATH <b>March 18 19 62</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>14 July 1906</b> 9. AGE (In years; last birthday) <b>55 yrs.</b> IF UNDER 1 YEAR: Months Days Hours M. n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b> 11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>JOHN DAVID FITEZ</b> 14. MOTHER'S MAIDEN NAME <b>MINNIE B. STAMBAUGH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>577-38-3298</b> 17. INFORMANT <b>Mrs. Christopher DeFrancisci</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO <b>2h Cerebral infarction</b> Conditions, if any, which gave rise to immediate cause (b) <b>18 hours</b> (a), stating the underlying cause last. (c) <b>INTERVA. BETWEEN ONSET AND DEATH</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>18 hours</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>3/18/62</b> 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <b>3/18/62</b> ... 19 <b>62</b> to <b>3/18</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on... <b>3/18/62</b> ... and that death occurred at <b>2:30AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Dr. Leon Levitsky, M.D.</b> 22b. DATE SIGNED <b>3-20-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon Levitsky, M.D.</b> 22d. ADDRESS <b>3408 R.I. Ave. Mt Rainier, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS	
23a. BURIAL, CREMATION / REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3-21-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Blue Ridge Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>THURMONT MARYLAND</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>WASH. D.C.</b> 25a. REC'D BY REGISTRAR <b>Francis J. Collins</b> 25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>	



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FOR STATE  
HEALTH DEPT.  
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1  
2  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit, file pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03609

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03603

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly D.O.A. c. LENGTH OF STAY IN b. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital 110 Leslie Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 110 Leslie Avenue	
3. NAME OF DECEASED (Type or print) Philip Flagman 4. DATE OF DEATH March 29th, 1962 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH JANUARY 4, 1899 9. AGE (in years last birthday) 63 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 10b. KIND OF BUSINESS OR INDUSTRY Radio-television Poland 11. FATHER'S NAME Jacob Flagman 12. C. CITIZEN OF WHAT COUNTRY? U. S. A. 13. FATHER'S NAME Jacob Flagman 14. MOTHER'S MAIDEN NAME Jennie Rudolph		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 213-10-7845 17. INFORMANT Helen Frances Flagman, same as # 2 18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 442 X DUE TO Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes since 1951 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/29/62 EXAMINER'S SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. Address (Street, city, town, or county) 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF April 2, 1962 22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith 22d. LOCATION (City, town, or county) Baltimore, Maryland 23. FUNERAL DIRECTOR Sol. Levinson & Bros Inc. 6080 Reisterstown Road 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Hines DATE APR 4 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03610

CERTIFICATE OF DEATH

03604

Item 3 Film G509 3/20/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1520 Sandy Spring Rd.</u>		d. STREET ADDRESS <u>1520 Sandy Spring Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Ann Gaigley</u>		4. DATE OF DEATH <u>March 11 1962</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 24 1889</u>	
9. AGE (In years, last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John N. Gaigley</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Mayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u>		16. SOCIAL SECURITY NO. <u>1520 Sandy Spring</u>	
17. INFORMANT <u>Miss Marie Gaigley</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Chronic Atherosclerosis</u>	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		20. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/9</u> to <u>3/10</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>62</u> and that death occurred at <u>11/9</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>J. M. Warren</u> M.D. 22b. DATE SIGNED <u>3/10</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/13/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cem</u>		23d. LOCATION (City, town or county) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Donaldson</u>		25a. REC'D BY REGISTRAR <u>16 62</u> 25b. REGISTRAR'S SIGNATURE <u>J. S. Thomas</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 must be filed with the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03611

03605

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u> c. LENGTH OF STAY IN 1b <u>35 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SOUTHERN MARYLAND HOSPITAL CENTER</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) e. STATE <u>PENNSYLVANIA</u> b. COUNTY <u>ALLEGHENY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CARNEGIE</u> d. STREET ADDRESS <u>558 CRESTNUT</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JAMES GRAHAM GAMBLE</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>MARCH 28</u> 19 <u>62</u> Month Day Year 8. DATE OF BIRTH <u>10/15/87</u> 9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days Hours MIN. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COUNTY PROPERTY ASSESSOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTY GOVT.</u> 11. BIRTHPLACE (County & State or foreign country) <u>ALLEGHENY, PA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES G. GAMBLE</u> 14. MOTHER'S MAIDEN NAME <u>LIZZIE MILLAR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>SON</u> 17. INFORMANT <u>JAMES GAMBLE</u> Address <u>PINE VIEW LANE CLINTON, MD.</u>	
<b>18. CAUSE OF DEATH</b> [Enter on y one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IN AN ITION</u> DUE TO <u>CARCINOMA OF THE BODY OF THE PANCREAS WITH GENERALIZED METASTASES</u> DUE TO <u>COMMON</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) 20a. TIME OF INJURY Month, Day, Year <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. PLACE OF INJURY (Home, farm, factory, street, etc.) <u>None</u> 20d. (City or town) (County) (State) <u>None</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1961</u> to <u>PRESENT</u> , that (I) (we) last saw the deceased alive on <u>MAR 27, 1962</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Arthur Shaver Jr.</u> M.D. 22c. PHYSICIAN'S NAME (Type or print) <u>ARTHUR SHAVER JR.</u>		22b. DATE SIGNED <u>3/28/62</u> 22d. ADDRESS <u>BRANCH AVE, CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Mar 31-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Charleena Cemetery Carnegie, Pa.</u> 23d. LOCATION (City, town or county) (State) <u>CLINTON, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Broas 1661-94 Apri R</u> ADDRESS <u>Wash 20 DC</u>		25a. REC'D BY REGISTRAR <u>APR 2 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Shaver</u>	



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3, should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for your files. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. The funeral director, Page 3, should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or designated agent, prior to burial, cremation, removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03612 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03606

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine - Rural</u> c. LENGTH OF STAY IN 1b <u>Transient</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dobson Clinic</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carlton</u> <u>Edward</u> <u>Garner</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1905</u>
9. AGE (In years last birthday) <u>56</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Garner</u>		14. MOTHER'S MAIDEN NAME <u>Jane Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-5350</u>	
17. INFORMANT <u>Elsie Wilmer, Faulkner, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO Coronary occlusion (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-1-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 3 '62</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02613

## CERTIFICATE OF DEATH

03607

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u> c. LENGTH OF STAY IN 1b <u>1 month and 6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn Dale Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>503 L. St., N.W.</u> d. STREET ADDRESS <u>503 L. St., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary</u> First <u>Mary</u> Middle <u>-</u> Last <u>Gates</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>25</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Negro</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>5/14/1882?</u> <b>9. AGE</b> (In years last birthday) <u>79?</u> yrs. <b>10. KIND OF BUSINESS OR INDUSTRY</b> <u>Unknown</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ga.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Mrs. Boatman, caseworker</u> Address <u>-</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Branchopneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (b) <u>-</u> (a), stating the underlying cause last. (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis; rectal stricture due to lymphopathia venereum; chronic pyelonephritis</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a.m. <u>-</u> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, factory, street, office bldg., etc.) <u>-</u> <b>20f. (City or town)</b> (County) (State) <u>-</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from ... 2/19/1962 to ... 3/25/1962, that (I) (we) last saw the deceased alive on ... 3/25/1962, and that death occurred at ... M, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Moe Weiss</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Moe Weiss, M.D.</u>		<b>22b. ADDRESS</b> <u>Glenn Dale Hospital</u> <u>Glenn Dale, Md.</u> <b>22d. DATE SIGNED</b> <u>3/25/62</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3-30-1962</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Harmony Memorial Park</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Huntsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAN 2 9 62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur A. ...</u>	



03614

CERTIFICATE OF DEATH

03608

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges County</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>45 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges County</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> d. STREET ADDRESS <u>14 Z Ridge Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louis</u> <u>Gerstel</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>March</u> <u>25</u> , <u>1962</u> Month Day Year	
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>4-12-90</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Collector</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retail Clothing</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>England</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Michael Gerstel</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Weissbroth</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>578-03-7792</u> <b>17. INFORMANT</b> <u>Lilian Gerstel</u> Address <u>14 Z Ridge Rd., Greenbelt</u> Md.		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angioblastic heart failure sec. to arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Paget Disease w/ sarcomatous degeneration</u> (a), stating the underlying cause last. (c) <u>sarcoma of left femur with metastases</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yr.</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (th's hospital) attended the deceased from</b> <u>February 2, 1962</u> <b>to</b> <u>March 25, 1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>March 25, 1962</u> , <b>and that death occurred at</b> <u>0:55 PM</u> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>Dr. Madarang</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Madarang</u>		<b>22b. DATE SIGNED</b> <u>3-26-62</u> <b>22d. ADDRESS</b> <u>Prince George's General Hosp., Cheverly, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3/27/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>National Mem. Park</u> <b>23d. LOCATION</b> (City, town or county) <u>Falls Church, Va.</u> (State) <u>  </u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u> <b>25c. DATE</b> <u>MAR 28 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be completely filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 9 Film 0310 4/2/62 mh 03615 03609											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b> c. LENGTH OF STAY IN lb <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>USAF HOSPITAL ANDREWS WASH 25</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b> d. STREET ADDRESS <b>4819 SUITLAND ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>(NMI)</b> Last <b>GORDON</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1962</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 APR 1915</b>		9. AGE (In years, months, days) <b>47 yrs</b>		IF UNDER 1 YEAR Months <b>14</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET- ARMY CWO</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>SOUTH HADLEY FALLS, MASS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>OLIVER GORDON (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>ADELE (NATTIE) GORDON MORIN</b>				Address <b>MRS. JUNE GORDON, 4819 SUITLAND RD, SUITLAND, MD</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES KOREAN</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>MRS. JUNE GORDON</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>9 03 . 0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Traumatic pneumothorax (R), RLL pneumonia + Septicemia</b> (c) <b>Traumatic fracture of Ribs 6 &amp; 7</b> cause test. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) Cirrhosis - advanced; 2) Delirium Tremens - convulsions 3) Oliguria</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b> <b>24 hrs</b> <b>24 hrs</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Trapped &amp; fell striking chest while walking to dining room</b>											
20b. DISCLOSE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 19.)				20c. INJURY OCCURRED 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20e. CITY OR TOWN <b>Suitland</b> (County) <b>Prince Georges</b> (State) <b>MD</b>				20f. (City or town) (County) (State)			
20c. TIME OF INJURY Hour <b>8:00</b> e.m. <b>22 Mar</b> 19 <b>62</b> p.m. <b>19 62</b>				20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 March, 1962</b> to <b>24 March, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>24 March, 1962</b> and that death occurred at <b>10:24 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>William K. Grove Capt USAF MC</b> M.D.				22b. DATE SIGNED <b>24 Mar 1962</b>				22c. PHYSICIAN'S NAME (Type) <b>WILLIAM K GROVE, Capt USAF MC</b>			
22d. ADDRESS <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>				22e. ADDRESS				22f. ADDRESS			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>BURIAL Mar. 29, 1962</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington, Virginia</b>				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.</b>				ADDRESS <b>517 11th St SE Wash, D.C.</b>				25a. REC'D BY REGISTRAR <b>MAR 29 '62</b>			
								25b. REGISTRAR'S SIGNATURE <b>Chambers &amp; Sons</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03615  
03610

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN 1b 4 days		d. STREET ADDRESS 9807 River Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clara HALL Gordy		4. DATE OF DEATH Month Day Year March 20 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept. 1885
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR: Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ELISHA HALL		14. MOTHER'S MAIDEN NAME HENRIETTA JARMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS RUTH MULLIKIN		Address 7601 WALTERS LANE DISTRICT HOGS, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure (b) Arteriosclerotic Cardiovascular Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4-22-1 DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-16 to 3-20, 1962, that (I) (we) last saw the deceased alive on 3-20, 1962, and that death occurred on 3-20, 1962, from the causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Pearson M.D.		22b. DATE SIGNED 3-21-62	
22c. PHYSICIAN'S NAME (Type) Dr. Benjamin S. Pearson		22d. ADDRESS 7018 Malboro Pike Dist Hogs Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-1962	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town or county) (State) BLADENSBURG, MD	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., Riverdale, Md		25a. REC'D BY REGISTRAR DATE MAR 23 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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03617  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03611  
Item 9 Film 6310 4/2/62 mb

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>31 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aquasco</u>	
3. NAME OF DECEASED (Type or print) <u>James Gray</u>		4. DATE OF DEATH <u>March 28 19 62</u>	
5 SEX <u>Male</u>		6 COLOR OR RACE <u>Black</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 17, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>Pr. Geo's Co. Maryland</u>	
13. FATHER'S NAME <u>Edward Benjamin Gray</u>		14. MOTHER'S MAIDEN NAME <u>Joanna Douglass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Delphinia Gray Aquasco, Md.</u>	
17. INFORMANT <u>Delphinia Gray Aquasco, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>ASCVD</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/28</u> to <u>3/28</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> , 19 <u>62</u> , and that death occurred at <u>2:00 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David S. Clayman</u> M.D.		22b. DATE <u>3/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. David S. Clayman</u>		22d. ADDRESS <u>6311 Baltimore Ave., Riverdale, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3/31/62</u>		23b. DATE THEREOF <u>John Wesley</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Aquasco, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George Stelson</u> ADDRESS <u>Aquasco, Maryland</u>		25a. REC'D BY REGISTRAR <u>3/29/62</u>	
		25b. REGISTRAR'S SIGNATURE <u>Clinton L. Haines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03618

03612

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>37 hrs. 40 Min.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Cottage City</b> d. STREET ADDRESS <b>3703 40th Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>		4. DATE OF DEATH <b>March 12 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-62</b>	
9. AGE (In years last birthday) <b>1</b> yrs. <b>13</b> months <b>40</b> days		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Earl Greer</b>		14. MOTHER'S MAIDEN NAME <b>Bobbie Louise Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Bilateral Pulmonary Atelectosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(2) Prematurity</b> DUE TO (c) <b>(3) Cephalohematoma</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/11</b> to <b>3/12</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3/11</b> , 19 <b>62</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Barry Rosenberg</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Barry Rosenberg</b>		22d. ADDRESS <b>1210 Chillum Manor Rd., West Hyattsville, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>3-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b>		25a. REC'D BY REGISTRAR <b>MAR 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove each page. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03619

CERTIFICATE OF DEATH

03613

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Brentwood</b> d. STREET ADDRESS <b>3804 Windom Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys E. Hamilton</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-12-1900</b>	
9. AGE (in years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>	
11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>25</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <b>Clerk - Dept. Store in Grand Island, Neb.</b>		13b. KIND OF BUSINESS OR INDUSTRY <b>Grand Island, Neb.</b>	
14. BIRTH (City, County & State or foreign country) <b>North Platte, Nebraska</b>		15. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. FATHER'S NAME <b>Guy Bush</b>		17. MOTHER'S MAIDEN NAME <b>Gertrude Anna Reed</b>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>506-28-845</b>		19. SOCIAL SECURITY NO. <b>506-28-845</b>	
20. INFORMANT <b>Guy Kent Hamilton</b>		21. ADDRESS <b>above</b>	
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>Fibrinous pericarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Mitral stenosis</b> (c), stating the underlying cause last. <b>Chronic Rheumatic Heart Disease</b>		23. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>1 month</b> <b>unknown</b>	
24. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobar pneumonia (left upper lobe--causative organism undetermined)</b>		25. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
26. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
28. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.		29. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
30. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		31. (City or town) (County) (State)	
32. I certify that (I) (this hospital) attended the deceased from <b>3-1-62</b> to <b>3-13-62</b> , that (I) (we) last saw the deceased alive on <b>3-13-62</b> , and that death occurred at <b>1:25</b> PM, from the causes and on the date stated above.		33. SIGNATURE <b>David S. Clayman</b> M.D. 24c. PHYSICIAN'S NAME (Type) <b>DAVID S. CLAYMAN</b>	
34. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		35. DATE <b>3/13/62</b>	
36. ADDRESS <b>6311 Balto Ave - Riverdale Md</b>		37. DATE <b>MAR 19 1962</b>	
38. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		39. DATE THEREOF <b>3/17/62</b>	
40. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		41. LOCATION (City, town or county) (State) <b>Grand Island, Nebraska</b>	
42. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home,</b>		43. ADDRESS <b>Pat. Rainier Maryland</b>	
44. REC'D BY REGISTRAR <b>MAR 19 1962</b>		45. REGISTRAR'S SIGNATURE <b>W. A. H. H. H.</b>	



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, the funeral director, Page 1, 2, and 3, should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03620

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03614

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Last Riverdale</b>	
c. LENGTH OF STAY IN 1b <b>11 days</b>		d. STREET ADDRESS <b>16317 Kenilworth Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clara Estelle Harbaugh</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 15, 1871</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. MOTHER'S MAIDEN NAME <b>Mary Jane Warren</b>	
13. FATHER'S NAME <b>Charles Harbaugh</b>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>	
15. SOCIAL SECURITY NO. <b>212-10-3293</b>		16. INFORMANT <b>Charles Seay, same as # 2</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4 500</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. <b>Fracture of the left hip</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:00</b> hour a.m. <b>3/6/ 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Last Riverdale P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF <b>3-20-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>		22e. REC'D BY REGISTRAR <b>MAR 20 '62</b>	
22f. REGISTRAR'S SIGNATURE <b>G. Howard Strong 3207 W. North Ave.,</b>		22g. REGISTRAR'S SIGNATURE <b>Colburn &amp; Kline</b>	

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

M

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

03611

03615

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>				c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>3917 Oliver Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alexina Harrison Harris</b>				4. DATE OF DEATH Month Day Year <b>March 28 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 1, 1885</b>	
9. AGE (in years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Cassius Alexander Harrison</b>				14. MOTHER'S MAIDEN NAME <b>Betty Devons</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Margaret Harris Tucker W. Lafayette, Indiana</b>			
17. INFORMANT <b>702 N. Grant Street</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Fractured left femur</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left femur</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>3-14 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hyattsville, P.G., Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Mar 30, 1962</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Scottsville Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Scottsville Virginia</b>			
23. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 2 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>				DATE			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03616

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if inst. put on: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>											
b. CITY OR TOWN (If outside corporate limits, with RURAL and give nearest town) <u>LAUREL</u>												c. CITY OR TOWN (If outside corporate limits, with RURAL and give nearest town) <u>BALTIMORE</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LAUREL SANITARIUM</u>												d. STREET ADDRESS <u>WINDSOR COURT Apts</u>											
3. NAME OF DECEASED (Type or print) <u>ABBIE M. HARTZOVET</u>												4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1962</u>											
5. SEX <u>FEMALE</u>												6. COLOR OR RACE <u>WHITE</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH Month <u>5</u> Day <u>12</u> Year <u>1961</u>											
9. AGE (In years last birthday) <u>23</u> yrs.												10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>											
11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>											
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>												12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>LYMAN A. WIECHAN</u>												14. MOTHER'S M.A.DEN NAME <u>SARAH E.</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>unknown</u>												16. SOCIAL SECURITY NO. <u>unknown</u>											
17. INFORMANT <u>Hosp Records LAUREL SANITARIUM</u>												Address <u>LAUREL SANITARIUM</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac infarction (426.1)</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>many yrs.</u>												INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>cerebral arteriosclerosis</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>00</u>												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>5-12-1961</u> to <u>9-23-1962</u> that (I) (we) last saw the deceased alive on <u>3-25-1962</u> and that death occurred at <u>PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>London P. Kraemer</u>												22b. DATE SIGNED <u>3-23-62</u>											
22c. PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>												22d. ADDRESS <u>LAUREL SANITARIUM LAUREL MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>												23b. DATE THEREOF <u>3/26/62</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>												23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Lickens</u>												25. REC'D BY REGISTRAR <u>Mar 27 '62</u>											
25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>																							





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any death is necessary, and the funeral director, Page 1, 2, and 3, should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 within 72 hours after death, Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03623 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03617

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission, if not) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		c. LENGTH OF STAY IN b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brandywine		d. STREET ADDRESS Lusby Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clinton Medical Center		D.O.A.		DATE OF DEATH March 12th, 1962	
3. NAME OF DECEASED (Type or print) Margaret Hawkins		4. DATE OF DEATH		5. SEX Female	
6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1900	
9. AGE (in years if UNDER 24 HRS. last birthday) 61 yrs.		10. MONTHS Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY At Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Jackson		14. MOTHER'S MAIDEN NAME Mary Pinkney		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Patrick Elsworth Hawkins		17. INFORMANT same as #2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-4-3x DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute pulmonary edema (c) Congestive heart failure DUE TO (a), stating the underlying cause last. Hypertensive heart disease		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
SIGNATURE James I. Boyd		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		DATE SIGNED 3/13/62		Address (Street city town or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-16-62		22c. NAME OF CEMETERY OR CREMATORY UNION BETHEL T.B. MARYLAND	
23. FUNERAL DIRECTOR MYRTLE K. ROLLINS		4339 HUNT PL., NE		DATE MAR 15 '62	



02624

## CERTIFICATE OF DEATH

Reg. Dist. No. 03618

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
c. LENGTH OF STAY IN 1b <u>16 days</u>		d. STREET ADDRESS <u>5229 N. 5th Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mrs. May's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nora</u> Middle <u>Alice</u> Last <u>HILL</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S. of Am.</u>		13. FATHER'S NAME <u>Joseph Taylor</u>	
14. MOTHER'S MAIDEN NAME <u>Albee McQuinn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Bertha V. Kinser</u> Address <u>Riverdale, Md. 5807 Hawthorne Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Malnutrition</u> DUE TO (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>8 months</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Liver Cystic Goiter (1 1/2 cm. dia.)</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>—</u> Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>Feb. 23, 1962</u> to <u>March 10, 1962</u> , that I last saw the deceased alive on <u>March 7, 1962</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walcott W. Gibson</u> M.D.		ADDRESS (Street, city or town, state) <u>4340 St. Barnabas Road (Marlow Heights, Md.)</u>	
PHYSICIAN'S NAME (Type) <u>Walcott W. Gibson, M.D.</u>		DATE SIGNED <u>Washington 20, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-13-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Flint Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Oakton, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. V. Chambers</u> ADDRESS <u>Kenneth St.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03625

## CERTIFICATE OF DEATH

03619

Items 2 & 7 film G-08 3/12/62 ink

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>MD</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE, MD</b> d. STREET ADDRESS <b>5005-60th AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM DAVID HOLLENBACK</b>		4. DATE OF DEATH Month Day Year <b>MARCH 5 1962</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 11, 1898</b>	9. AGE (In years last birthday) <b>63</b> yrs.	10. IF UNDER 1 YEAR Months Days <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MUSIC PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM HOLLENBACK</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>196-01-8584</b>		16. SOCIAL SECURITY NO. <b>MRS. JAMES NEARY</b>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>COR PULMONALE</b> (c) <b>SILICOSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n)				INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 YEARS</b> <b>YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1960</b> to <b>MARCH 1962</b> , that (I) (we) last saw the deceased alive on <b>3/4 1962</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>James Duke</b>		22b. ADDRESS <b>475 H 117th</b>		22c. DATE <b>3/5/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. DATE	
23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE THEREOF <b>3/9/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Josephs</b>	23d. LOCATION (City, town or county) (State) <b>Scranton Pa</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. H. Haffell</b>		25a. REC'D BY REGISTRAR <b>7 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03626

## CERTIFICATE OF DEATH

Reg. Dist. No.

03620

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 2, Box 80</b>				d. STREET ADDRESS <b>Rt. 2, Box 80</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Humphrey</b> Last <b>Hook IV.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1888</b>	9. AGE (In years last birthday) <b>74</b> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard H. Hook III</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Wells</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-14-2102</b>		17. INFORMANT <b>Mrs. Ida Beall Hook-Same as Item 2.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.0</b> DUE TO <b>Cachexia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Cecum</b> DUE TO <b>Metastases to liver</b> (c) <b>Metastases to liver</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>unk.</b> <b>unk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1, 1961</b> , to <b>14 Mar 1962</b> , that I last saw the deceased alive on <b>14 Mar 1962</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above							
ACTUAL SIGNATURE <b>R. B. Sasscer</b> M.D. <b>Upper Marlboro, Md.</b>				ADDRESS (Street, city or town, state) <b>Upper Marlboro, Md.</b> DATE SIGNED <b>3/14/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Forestville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro</b>				24a. REC'D BY REGISTRAR <b>MAR 21 '62</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03627

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03621

1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Carrollton

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Carrollton

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6010 84th Avenue

d. STREET ADDRESS

6010 84th Avenue

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

DAVID

DANIEL

HORAN

4. DATE OF DEATH

March

24

19 62

5. SEX

Male

White

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☒

8. DATE OF BIRTH

Nov. 26, 1958

9. AGE (In years last birthday)

3

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

None

11. BIRTHPLACE (State or foreign country)

FLORIDA

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Daniel Horan

14. MOTHER'S MAIDEN NAME

Loretta Mary Solack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO

None

17. INFORMANT

Robert D. Horan Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Convulsive disorder

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

DUE TO

DUE TO

(c)

Cerebral palsy

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3/24/62

22a. BURIAL CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/27/1962

22c. NAME OF CEMETERY OR CREMATORY

Arlington Nat'l Cem.

22d. LOCATION (City, town, or country)

Arlington, Virginia

23. FUNERAL DIRECTOR

W.W.Chambers Co., Riverdale, Md.

24a. REC'D BY REGISTRAR

MAR 27 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the funeral director. Page 1, 2, and 3 of the certificate should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 2 should be retained for your files. Page 3 should be forwarded to the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03622

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4658 Homer Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 4658 Homer Avenue	
3. NAME OF DECEASED (Type or print) Eugene Edgar 4. DATE OF DEATH March 16 19 62		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH APRIL 13, 1899 9. AGE (In years last birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OCEANOGRAPHER 10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T 11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALBERT S. HOWELL 14. MOTHER'S MAIDEN NAME ELYDIA JUDGE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 16. SOCIAL SECURITY NO. 090-03-467 17. INFORMANT MRS ALICE DAILEY Address 139 FOREST ROAD FANWOOD NEW JERSEY.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 49 (b) LOBAR PNEUMONIA (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II, of item 18.) 20c. TIME OF INJURY Month Day Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED 3/16/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3-21-1962 22c. NAME OF CEMETERY OR CREMATORY Arlington National 22d. LOCATION (City, town, or country) Arlington, Virginia 23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, MARYLAND ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAR 23 '62			



FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
SM 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03629 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03623

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxon Hill c. LENGTH OF STAY in lb 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4907 Forest Drive		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 14 Oxon Hill d. STREET ADDRESS 4907 Forest Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Clifford Hunt		4. DATE OF DEATH March 10 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1908 9. AGE (in years last birthday) 53 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radar technician		10b. KIND OF BUSINESS OR INDUSTRY Communication	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clifford Patrick Hunt		14. MOTHER'S MAIDEN NAME Jennie Watkins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Eileen Dorothy Hunt, same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3/10/62 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 13-62	
22c. NAME OF CEMETERY OR CREMATORY Wash. National		22d. LOCATION (City, town, or country) (State) Southland Md	
23. FUNERAL DIRECTOR Simmons Bros 1661-9d Howard Wash DC & E		24a. REC'D BY REGISTRAR DATE MAR 13 '62	
		24b. REGISTRAR'S SIGNATURE Charles L. Thomas	



Items 14 & 22a Film G-508 5/26/62 1wk

1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the funeral director, Page 5, and the funeral director, Page 5, to execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Res. since before adm. ssion) a. STATE <b>District of Columbia</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. STREET ADDRESS <b>1648 Trinidad Avenue, N.E.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <b>Emanuel Hunter</b>		4. DATE OF DEATH <b>March 2, 1962</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1894</b>		9. AGE (In years last birthday) <b>67</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>U.S. Gov't.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Eugene Hunter</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>256-10-2939</b>		17. INFORMANT <b>Gussie Lenetta Hunter, Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, in any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Cardiovascular renal disease</b> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>New Bern, North Carolina</b>		(County)		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Bern, North Carolina</b>		22d. LOCAT ON (City, town, or country) <b>New Bern, North Carolina</b>		22e. (State)		23. FUNERAL DIRECTOR <b>Frazier's Funeral Home, 389 R. I. Ave. NW., DC.</b>	
24a. REC'D BY REGISTRAR <b>7 '62</b>		24b. REGISTRAR'S SIGNATURE <b>James I. Boyd</b>		24c. DATE SIGNED <b>3/2/62</b>		24d. ADDRESS (Street, city, town, or county)		24e. (State)		24f. (City or town)	





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03625

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY in lb <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suitland Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1629 30th St. S.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Boone C HUTCHINSON</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>March 21, 1962</u> Month Day Year	
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept. 23, 1874</u> Year	<b>9. AGE</b> (In years last birthday) <u>87</u> yrs.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Paper Hanger &amp; Painter</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Building</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>St. Mary's County, Md.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. of America</u>
<b>13. FATHER'S NAME</b> <u>Joseph Hutchinson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna C. Johnson</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>577-10-4442</u>	
<b>17. INFORMANT</b> <u>Mrs. Louise Merritt</u> Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage Rb. Hemiplegia</u> (b) <u>Arteriosclerosis Generalized</u> (c) <u>Arteriosclerotic Heart Disease about 20 yrs.</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Arteriosclerotic Heart Disease about 20 yrs.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>40 yrs</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 17, 1954</u> , to <u>March 21, 1962</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>March 21, 1962</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Walcott W. Gibson</u> M.D.		<b>22b. DATE SIGNED</b> <u>March 21, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Walcott W. Gibson, M.D.</u>		<b>22d. ADDRESS</b> <u>4310 St. Barnabas Road, (21, D.C.)</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>3-24-62</u>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <u>Cedar Hill</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 23 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur A. Harris</u>		<b>25c. ADDRESS</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03632 CERTIFICATE OF DEATH 03626

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 yr., 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5101 Just St., N.E.	
<b>3. NAME OF DECEASED</b> (Type or print) Mabel B. Jackson First Middle Last b. COLOR OR RACE Negro c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> d. DATE OF BIRTH 1/13/08 e. AGE (In years last birthday) 54 yrs. f. IF UNDER 1 YEAR Months Days g. IF UNDER 24 HRS. Hours Min.		<b>4. DATE OF DEATH</b> 3 27 19 62 Month Day Year h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> Female <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Laundry worker <b>10b. KIND OF BUSINESS OR INDUSTRY</b> Unknown <b>11. BIRTHPLACE</b> (County & State, or foreign country) Va. <b>12. CITIZEN OF WHAT COUNTRY?</b> USA		<b>13. FATHER'S NAME</b> Robert L. Edmonds <b>14. MOTHER'S MAIDEN NAME</b> Marie Palmer	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No <b>16. SOCIAL SECURITY NO.</b> 578-48-1764 <b>17. INFORMANT</b> Decedent Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, pulmonary, massive 2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary tuberculosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary atherosclerosis	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year 19 3/15/1962 Hour e.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>INTERVAL BETWEEN ONSET AND DEATH</b> 1 day 1 year	
<b>21. I certify that (I) (this hospital) attended the deceased from 3/15/1962 to 3/27/1962, that (I) (we) last saw the deceased alive on 3/27/1962, and that death occurred at P.M., from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> Moe Weiss <b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M.D. <b>22d. ADDRESS</b> Glenn Dale Hospital, Glenn Dale, Md.		<b>22b. DATE SIGNED</b> 3/27/62 <b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) 3-31-62 <b>23b. DATE THEREOF</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town or county) Petersburg VA <b>23e. (State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Henry Washington Son 4925 <b>25a. REC'D BY REGISTRAR</b> DATE APR 3 '62 <b>25b. REGISTRAR'S SIGNATURE</b> Arthur L. Harris			

N.C.



VR A15 (4)  
15M 7/61

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

MEDICAL CERTIFICATION

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**HOSPITAL OR ATTENDING PHYSICIAN:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
036324 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03628

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If instituted on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hall</u>	
c. LENGTH OF STAY IN B <u>10 Hrs.</u>		d. STREET ADDRESS <u>214 Central Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Hamilton Jefferson</u>		4. DATE OF DEATH <u>March 8th, 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1891</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Marcel</u>		14. MOTHER'S MAIDEN NAME <u>Doris Sims</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Evelyn May Parker</u>	
17. INFORMANT <u>Same as #2</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio vascular renal disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar. 11, 62</u>		22b. DATE THEREOF <u>PLUM Point</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pinkney Sewell</u>		22d. LOCATION (City, town, or country) (State) <u>Calvert Md</u>	
23. FUNERAL DIRECTOR <u>Prince Frederick,</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Carroll S. Evans</u>			





## CERTIFICATE OF DEATH

Reg. Dist. No. 03629

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cedar Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cedar Heights</i>	
c. LENGTH OF STAY IN 1b <i>2+ yrs.</i>		d. STREET ADDRESS <i>904-64 Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>904-64 Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Florence Johnson</i>		4. DATE OF DEATH <i>March 2</i> 19 <i>62</i>	
5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1884</i>
9. AGE (In years last birthday) <i>77</i>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>2</i>	11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>P. Geo. Co. Welfare Dept.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis</i> DUE TO (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) <i>Unknown</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lymphangitis</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1960</i> , 19 <i>60</i> , to <i>3-2-62</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>3-1-62</i> , and that death occurred at <i>7:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. N.E.</i> DATE SIGNED <i>Washington 27, D.C.</i>			
ACTUAL SIGNATURE <i>John W. Robinson, M.D.</i>			
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3-8-62</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington &amp; Sons</i>	22d. LOCATION (City, town, or county) (State) <i>Highland Park, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry S. Washington &amp; Sons</i> ADDRESS <i>4925 Denne Ave</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 9 '62</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrars should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03636

CERTIFICATE OF DEATH

03630

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 1 month and 23 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 910 O. St., N.W.	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Hugh B. Johnson		<b>4. DATE OF DEATH</b> Month Day Year 3 7 19 62	
<b>5. SEX</b> Male	<b>6. COLOR OR RACE</b> Negro	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> 11/7/13
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Boot-black		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Mac's Valet Shop	<b>11. BIRTHPLACE</b> (County & State, or foreign country) Va.
<b>13. FATHER'S NAME</b> John Willie Johnson		<b>14. MOTHER'S MAIDEN NAME</b> Rosa Lovings	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) No		<b>16. SOCIAL SECURITY NO.</b> 577-26-1260	<b>17. INFORMANT</b> Decedent
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinomatosis, generalized 150X DUE TO Carcinoma of the esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from 1/12/1962 to 3/7/1962, that (I) (we) last saw the deceased alive on 3/7/1962, and that death occurred at A.M., from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Moe Weiss		<b>22b. DATE SIGNED</b> 3/7/1962	
<b>22c. PHYSICIAN'S NAME</b> (Type) Moe Weiss, M.D.		<b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) BURIAL	<b>23b. DATE THEREOF</b> 3/9/62	<b>23c. NAME OF CEMETERY OR CREMATORY</b>	<b>23d. LOCATION</b> (City, town or county) (State) Staunton, Virginia
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> J. Stewart		<b>25a. REC'D BY REGISTRAR</b> MAR 12 '62	<b>25b. REGISTRAR'S SIGNATURE</b>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03637

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03631

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 1, 2, and 3 of the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

M

### 1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY IN 1b

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

### 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Mount Rainier

d. STREET ADDRESS

4604 25th Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

Julia

M.

Kelly

### 4. DATE OF DEATH

March

2

1962

### 5. SEX

Female

### 6. COLOR OR RACE

White

### 7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

### 8. DATE OF BIRTH

Sept. 12, 1891

### 9. AGE (In years last birthday)

70 yrs.

### 10. IF UNDER 1 YEAR

Months Days Hours Min.

### 11. IF UNDER 24 HRS.

Hours Min.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

### 10b. KIND OF BUSINESS OR INDUSTRY

Own Home

### 11. BIRTHPLACE (State or foreign country)

Pennsylvania

### 12. CITIZEN OF WHAT COUNTRY?

U. S. A.

### 13. FATHER'S NAME

Patrick Ducey

### 14. MOTHER'S MAIDEN NAME

Mary Derskin

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

### 16. SOCIAL SECURITY NO.

None

### 17. INFORMANT

John Henry Kelly, same as # 2

Address

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

4 + 2 X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

(c)

Acute congestive heart failure

Cardiovascular renal disease

#### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

### 19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

### MEDICAL CERTIFICATION

#### 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

#### 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

#### 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m.

#### 20d. INJURY OCCURRED While at work ☐ Not While at work ☐

#### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

#### 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

### ACTUAL SIGNATURE

James I. Boyd

M.D.

### CHIEF MEDICAL EXAMINER ☐

### ASSISTANT MEDICAL EXAMINER ☐

### DEPUTY MEDICAL EXAMINER ☒

### DATE SIGNED

3/2/62

### EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

### Address (Street, city, town, or county)

### 22a. BURIAL, CREMATION, REMOVAL (Specify)

### 22b. DATE THEREOF

### 22c. NAME OF CEMETERY OR CREMATORY

### 22d. LOCATION (City, town, or country) (State)

Burial

3/6/62

Arlington National

Arlington, Va.

### 23. FUNERAL DIRECTOR

### ADDRESS

### REC'D BY REGISTRAR

### 24b. REGISTRAR'S SIGNATURE

Malley's Funeral Home Inc.

md

7 '62

Signature



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4. The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

VR A15 (4)  
ISM 9/59

03638

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03632

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN TB 22 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bloomfield		d. STREET ADDRESS 357 Belleville Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MIDDLE Last RICHARD P. KENNEDY		4. DATE OF DEATH Month Day Year Mar. 1st 19 62	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/88
9 AGE (In years last birthday) 73		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker		10b. KIND OF BUSINESS OR INDUSTRY Glasgow, Scotland	
11. BIRTHPLACE (State or foreign country) Glasgow, Scotland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Kennedy		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, unknown, (If yes, give war or dates of service): No		16 SOCIAL SECURITY NO. Donald Kennedy, 3814-Y St., S.E., S.E.	
17 INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis (b) Atherosclerosis + Congestive Heart Failure (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 20 1962 to Mar 1 1962 that (I) (we) last saw the deceased alive on Mar 1 1962, and that death occurred at 12 M. from the causes and on the date stated above.			
22a. SIGNATURE J. H. Thibadeau		22b. DATE SIGNED Mar. 1-1962	
22c. PHYSICIAN'S NAME (Type) Jos. H. Thibadeau		22d. ADDRESS 3112--Alabama Ave., S.E. Wash. 20 DC	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland MD	
24 FUNERAL DIRECTOR'S SIGNATURE Brimmors Bros. 1661-GARDEN HILL RD. S.E.		25a REC'D BY REGISTRAR DATE MAR 2 '62	
ADDRESS WASH. 20 DC		25b REGISTRAR'S SIGNATURE C. H. HARRIS	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03639 CERTIFICATE OF DEATH 03633

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE CO.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> c. LENGTH OF STAY IN 1b <b>74</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Leland Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>5008 Cook Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William D. Kitchen</b>		4. DATE OF DEATH <b>March 11 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-95</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fed. Empl.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>100p. Records</b>	
17. INFORMANT <b>As above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162 X Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Calcinoma of Lungs.</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>8:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles L. House</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/13/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>Hyattsville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>		25c. DATE <b>MAR 13 '62</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03640

CERTIFICATE OF DEATH

03634

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>	
c. LENGTH OF STAY IN 1b <b>11 years</b>		d. STREET ADDRESS <b>4922 La Salle Road N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll Manor 4922 La Salle Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>M.</b> Last <b>KNEESSI</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 20, 1883</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Frank J Prott</b>		14. MOTHER'S MAIDEN NAME <b>? Koch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Stewart Kneessi</b>		Address <b>Riverdale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic carcinoma generalized</b> DUE TO <b>Carcinoma of the breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>More than three years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anterior chronic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 15, 1962</b> to <b>March 15, 1962</b> that (I) (we) last saw the deceased alive on <b>March 15, 1962</b> and that death occurred on <b>March 15, 1962</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>D. R. Purdie</b>		22b. DATE SIGNED <b>March 15, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. R. Purdie</b>		22d. ADDRESS <b>Riverdale Md</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 17, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>March 20 '62</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Carroll E. Pinner</b>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03641

03635

1  
FOR STATE  
HEALTH DEPT.  
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 should be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 may be retained for your files. Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>East Riverdale</b> c. LENGTH OF STAY in 1b <b>11 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5211 58th Avenue</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Prince George's</b> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 East Riverdale</b> h. STREET ADDRESS <b>5211 58th Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>ZORA VIRGINIA KRITES</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 7, 1897</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>62</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11c. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES SWISHER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA ALBRIGHT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Arthur Cristian Krites Same as #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42x</b> DUE TO <b>Acute pulmonary edema</b> Conditions, if any which gave rise to immediate cause (b) <b>Congestive heart failure</b> (a), stating the underlying cause last. DUE TO (c) <b>Cardiovascular renal disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>3/24/62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>			
24a. REC'D BY REGISTRAR <b>MAR 29 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krites</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03642					03636				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if instit on. Residence before admission)				
a. COUNTY <b>PRINCE GEORGES</b>					a. STATE <b>MARYLAND</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>					b. COUNTY <b>PRINCE GEORGES</b>				
c. LENGTH OF STAY IN 1b <b>1 DAY</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>					d. STREET ADDRESS <b>3308 TERRACE DRIVE SE</b>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last <b>FRANK JOSEPH LANDRY JR</b>					Month Day Year <b>MARCH 21 19 62</b>				
5. SEX <b>MALE</b>					6. COLOR OR RACE <b>CAUCASIAN</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>XX</b>					8. DATE OF BIRTH				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) yrs Months Days <b>20 MARCH 1962</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>				
11. BIRTHPLACE (County & State, or foreign country) <b>PRINCE GEORGES, MARYLAND</b>					12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>				
13. FATHER'S NAME <b>FRANK JOSEPH LANDRY SR</b>					14. MOTHER'S MAIDEN NAME <b>ETHEL FRANCES BAILEY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>				
17. INFORMANT <b>FRANK J LANDRY (FATHER) SAME AS ITEM #2</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Respiratory arrest of unknown origin.</b> 76 DUE TO intraventricular, right cerebrum, 3d and 4th ventricle (b) Atelectasis, resorption, bilateral, cause undetermined DUE TO Prematurity & Immaturity (c) <b>28 hrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>28 hrs</b>					INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>20 MARCH</b> 19 <b>62</b> to <b>21 MARCH</b> 19 <b>62</b> that (I) <del>XX</del> last saw the deceased alive on <b>21 MARCH</b> 19 <b>62</b> and that death occurred at <b>1030P</b> from the causes and on the date stated above.					22b. DATE SIGNED <b>21 MARCH 62</b>				
22a. SIGNATURE <b>W. W. Chambers</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <b>JOHN D. BLACKBURN, Capt USAF MC</b>					22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>3-26-62</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Hall</b>					23d. LOCATION (City, town or county) (State) <b>St Myer Va.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co</b>					25a. REC'D BY REGISTRAR <b>DATE MAR 27 '62</b>				
ADDRESS <b>517-10th St SE</b>					25b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>				





FOR STATE  
HEALTH DEPT.

12. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use the funeral director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03643 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03637

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Coshocton</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Walhonding</b>			
c. LENGTH OF STAY IN 1b <b>3 hrs</b>				d. STREET ADDRESS <b>Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma Jane Langdon</b>				4. DATE OF DEATH Month Day Year <b>March 5 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1895</b>	
9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Robert Bennett</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Tanner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>John Frederick Langdon, same as # 2</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>C ardiovascular renal disease</b> (c) <b>44-3</b> DUE TO (e), stating the underlying cause last. } DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James I. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>March 9-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>New Castle</b>				22d. LOCATION (City, town, or country) (State) <b>New Castle, Ohio</b>			
23. FUNERAL DIRECTOR <b>Sumner Bros</b>				24a. REC'D BY REGISTRAR <b>8 '62</b>			
ADDRESS <b>1661-9d Hype Rd SE</b>				24b. REGISTRAR'S SIGNATURE <b>L. S. Hines</b>			

Wash DC



C. Aubrey S. Kinnear



CERTIFICATE OF DEATH

03645

03639

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>University Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Memorial</u>		d. STREET ADDRESS <u>4220 Sheridan St</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>A</u> Last <u>Lesner</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-07</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraving</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geological Survey Interior Dept.</u>	
11. BIRTHPLACE County & State, or foreign country <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nicholas Lesner</u>		14. MOTHER'S MAIDEN NAME <u>Roth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 44 0458</u>	
17. INFORMANT <u>Area Lesner University Park, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4</u> DUE TO (b) <u>Chronic arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>arteriosclerotic heart disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 2, 1962</u> to <u>March 2, 1962</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1962</u> and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. W. Martin M.D.</u>		22b. DATE SIGNED <u>3-2-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. W. Martin M.D.</u>		22d. ADDRESS <u>Riverdale Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25. REGISTRAR'S SIGNATURE <u>Walter S. Hanna</u>	
ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 7 1962</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the attending physician and certified to the funeral director. After this certificate has been signed by the attending physician and certified to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03645  
03640

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) c. LENGTH OF STAY IN 1b 11 mo., 22 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY District of Columbia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 108 Atlantic St., S.E. Apt 303	
3. NAME OF DECEASED (Type or print) JULIAN CLARK LEVELL First Middle Last		4. DATE OF DEATH March 9 1962 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1900 9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab-driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi	11. BIRTHPLACE (County & State, or foreign country) Laray, Virginia
13. FATHER'S NAME Bureguard Levell		14. MOTHER'S MAIDEN NAME Martha Skelton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Person
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, recurrent + 200 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery heart disease (c) DUE TO (e), stating the underlying cause last. Benign prostatic hypertrophy with urethral obstruction.			INTERVAL BETWEEN ONSET AND DEATH 1 day unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/15/62 to 3/9/62, that (I) (we) last saw the deceased alive on 3/9/1962, and that death occurred at 5:41 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED March 9, 1962	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital. Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/13/62	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town or county) (State) Bladensburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Simon B. Butler		25a. REC'D BY REGISTRAR DATE MAR 13 '62	
25b. REGISTRAR'S SIGNATURE C. S. S. S.			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03647

03642

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> c. LENGTH OF STAY IN 1b <u>55 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>910 Myrtle Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> d. STREET ADDRESS <u>910 Myrtle Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leonard Lowman</u> First Middle Last 4. DATE OF DEATH <u>March 3, 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 31 1870</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>91</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Horse Farm</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Margie Lowman</u> Address <u>Bowie, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular-Renal Dis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Essential Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) County (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 1956 to <u>Mar</u> 1962 that (I) (we) last saw the deceased alive on <u>March 2</u> 1962 and that death occurred at <u>M</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>D. Henry A. Wise Jr.</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Henry A. Wise, Jr.</u> 22d. ADDRESS <u>3/3/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 6, 1962</u> 23c. NAME OF CEMETERY OR CREMATORIUM <u>Nicholas Memorial</u> 23d. LOCATION (City, town or county) (State) <u>Odenton Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 25a. REC'D BY REGISTRAR <u>WAR</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> DATE <u>7 '62</u>	



CERTIFICATE OF DEATH

03648

03643

1. PLACE OF DEATH  
a. COUNTY Parince Georges MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland  
c. LENGTH OF STAY IN 1b 1 Mo. 12d  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Parince Georges  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oren Hill  
d. STREET ADDRESS 4408 Brockton Rd.

3. NAME OF DECEASED (Type or print) Syons, James  
First Middle Last  
4. DATE OF DEATH March 12, 1962  
Month Day Year  
5. SEX M  
6. COLOR OR RACE W  
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH 10/4/79  
9. AGE (In years last birthday) 82  
If UNDER 1 YEAR: Months Days Hours Min.  
If UNDER 24 HRS.: Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired painter  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (County & State, or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Syons, James  
14. MOTHER'S MAIDEN NAME Annie Keane

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) No  
16. SOCIAL SECURITY NO. 578-01-3263  
17. INFORMANT Bernard Syons-Vienno, Virginia  
18. CAUSE OF DEATH (Enter only one cause prevailing for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease  
DUE TO Arterio Sclerotic Heart Disease  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. yes  
DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATIVE TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Snoring  
Carcinoma of Colon Rectum  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from... 3/9/62 to 3/12/62, that (I) (we) last saw the deceased alive on... 3/9/62, and that death occurred at... 3/12/62, from the causes and on the date stated above.  
22a. SIGNATURE J. G. Donovan  
22b. DATE SIGNED 3/14/62  
22c. PHYSICIAN'S NAME (Type) J. G. Donovan  
22d. ADDRESS 2811 P. Ave. N.E.  
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
23b. DATE THEREOF 3/15/62  
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem  
23d. LOCATION (City, town or county) (State) Washington, D.C.  
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home  
25a. REC'D BY REGISTRAR MAR 14 '62  
25b. REGISTRAR'S SIGNATURE Wm L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and fill in page 4 with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



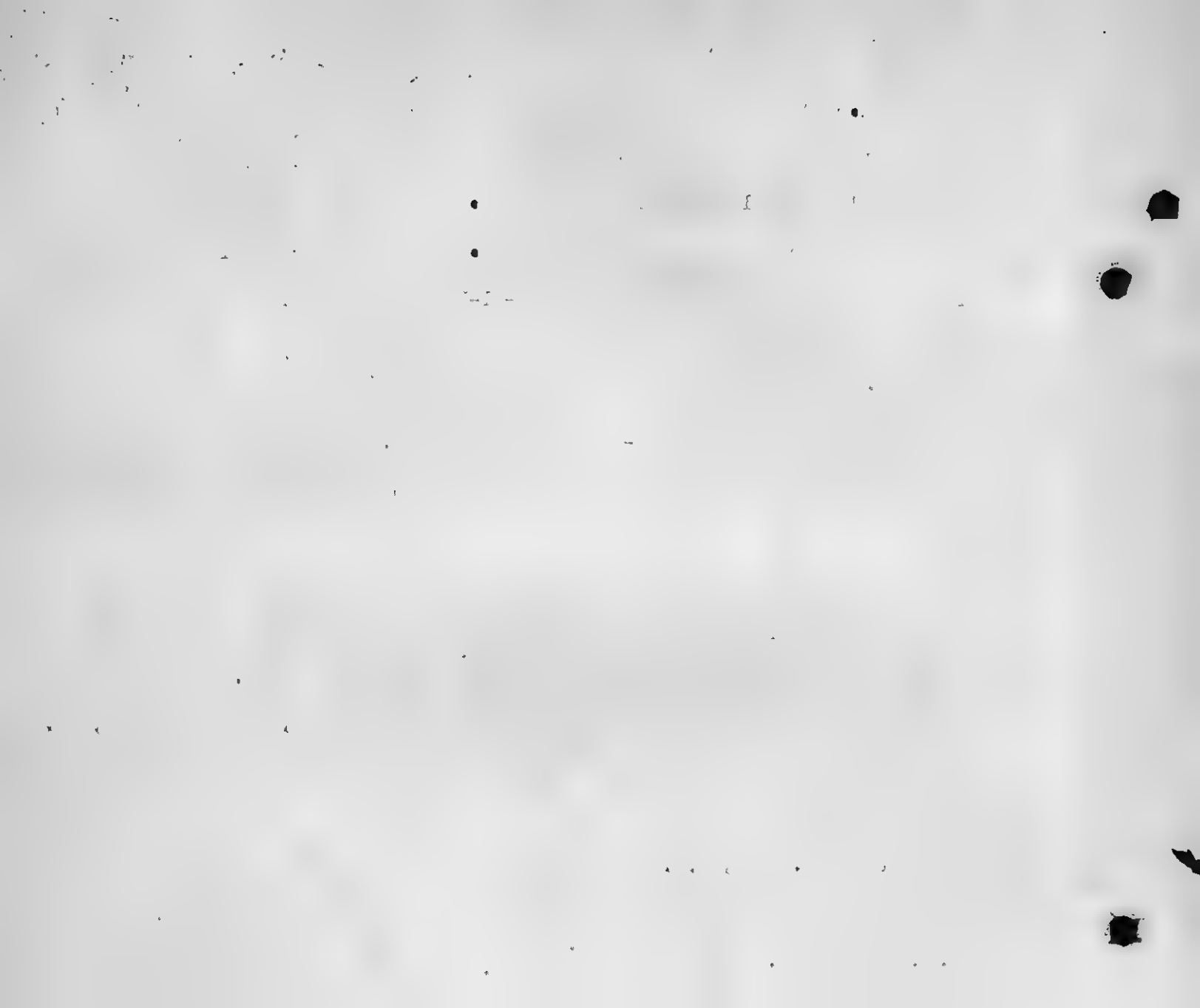
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
SM 9/60

<div style="display: flex; justify-content: space-between;"> <div> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>03649</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>03644</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Prince George's</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b></p> <p>c. LENGTH OF STAY in 1b <b>7 days</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>14 Lanham</b></p> <p>d. STREET ADDRESS <b>Box 266 Defense Highway</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <b>Norman</b> Middle <b>Magnus</b> Last <b>MacLeod</b></p>						<p>4. DATE OF DEATH <b>March 31</b> 19 <b>62</b></p> <p>Day Month Year</p>					
<p>5. SEX <b>Male</b></p>		<p>6. COLOR OR RACE <b>Caucasian</b></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>6-21-1900</b></p>		<p>9. AGE (In years last birthday) <b>61</b> yrs.</p>		<p>IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired News Reporter</b></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>William C. MacLeod</b></p>				<p>14. MOTHER'S MAIDEN NAME <b>Sarah Jane McKelvie</b></p>							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <b>221-26-7944</b></p>				<p>17. INFORMANT <b>Margaret S. MacLeod</b> same as #2 Address</p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <b>Second and Third Degree Burns (43% body area)</b></p> <p>716.0 DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____</p> <p>(c) _____</p>										<p>INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p><b>Coronary Arteriosclerotic Heart Disease</b></p>											
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Clothing ignited when deceased struck a match.</b></p>							
<p>20c. TIME OF INJURY Month, Day, Year <b>5 March 25, 1962</b></p> <p>Hour a.m. p.m.</p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/></p>				<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b></p>			
				<p>20f. (City or town) <b>Lanham, Prince Georges, Md.</b></p>				<p>(County) (State)</p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>											
<p>ACTUAL SIGNATURE <b>James I. Boyd</b></p> <p>EXAMINER'S NAME (Type) <b>James I. Boyd, M.D.</b></p>						<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>Address (Street, city, town, or county)</p>					
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b></p>						<p>22b. DATE THEREOF <b>4/4/62</b></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <b>Fernwood Cemetery</b></p>		<p>22d. LOCATION (City, town, or country) (State) <b>Philadelphia, Pa.</b></p>	
<p>23. FUNERAL DIRECTOR <b>The S.H. Hines Co.</b> 2901 14th St. N.W. Washington 9, D.C.</p>						<p>24a. REC'D BY REGISTRAR <b>APR 5 1962</b></p>		<p>24b. REGISTRAR'S SIGNATURE <b>J. I. Boyd</b></p>		<p>DATE</p>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03650				CERTIFICATE OF DEATH				03645			
Item 13 From birth certificate											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN IS <b>15 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b> d. STREET ADDRESS <b>6733 Prince Georges</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Baby "A" Boy MacMillan</b>				4. DATE OF DEATH Month Day Year <b>March 24 19 62</b>				5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>24 March 1962</b>				9. AGE (In years last birthday) yrs. Months Days <b>15</b>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b> 11. BIRTHPLACE (County & State or foreign country) <b>U.S.A.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frederick Shaw MacMillan</b>				14. MOTHER'S MAIDEN NAME <b>Edna Pearl Lawrence</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>None</b> 16. SOCIAL SECURITY NO. <b>Mother</b> 17. INFORMANT <b>Same as above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>at birth</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>3-24</b> , <b>1962</b> , to <b>3-24</b> , <b>1962</b> that (I) (we) last saw the deceased alive on <b>3-24</b> , <b>1962</b> , and that death occurred at <b>6:14 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Thomas A. Christensen</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Thomas A. Christensen</b>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>6905 Baltimore Ave., College Park,</b>				22b. DATE SIGNED <b>9/25/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>3-31-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hospital</b> 23d. LOCATION (City, town or county) (State) <b>Cheverly, Maryland</b>				24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b> 25a. REC'D BY REGISTRAR <b>APR 3 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. French</b>			

2-145960





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FUNDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03651

Item 13 info. from birth certificate

03646

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>27 hrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b> d. STREET ADDRESS <b>6733 Prince George Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Baby Boy "B"</b> Middle <b>MacMillan</b> Last <b>MacMillan</b> 4. DATE OF DEATH <b>March 25 19 62</b>		<b>5. SEX</b> <b>Male</b> <b>White</b> <b>WIDOWED</b> <b>DIVORCED</b> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> 6. COLOR OR RACE <b>White</b> <b>WIDOWED</b> <b>DIVORCED</b> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>24 March 1952</b> 9. AGE (In years last birthday) <b>10</b> yrs <b>10</b> months <b>10</b> days <b>27</b> hours <b>27</b> min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>10c. CITIZEN OF WHAT COUNTRY?</b> <b>U.S. A.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S. A.</b>	
<b>13. FATHER'S NAME</b> <b>Frederick Shaw MacMillan</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Edna Pearl Lawrence</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Mother</b> <b>Same as above</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>prematurity</b> Conditions, if any, which gave rise to immediate cause (b) <b>as follows</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from 3-24 1962, to 3-25 1962, that (I) (we) last saw the deceased alive on 3-25 1962, and that death occurred at 6:40AM from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>Dr. Thomas A. Christensen</b> M.D. <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Thomas A. Christensen</b> <b>22d. ADDRESS</b> <b>6905 Baltimore Ave., College Park, Md.</b> <b>22b. DATE SIGNED</b> <b>3/25/62</b>		<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <b>23b. DATE THEREOF</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>23d. LOCATION (City, town or county)</b> (State) <b>Cremation</b> <b>3-31-62</b> <b>Prince Geo. Gen. Hospital</b> <b>Cheverly, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Harry W. Penn, Jr., Administrator</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>APR 3 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Christina S. Thomas</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03652 CERTIFICATE OF DEATH 03647

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>LAUREL SANITARIUM</b>		d. STREET ADDRESS <b>6216 HIPTOP Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>JDA</b> Middle <b>S.</b> Last <b>MAKODZUB</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-1872</b>
9. AGE (In years last birthday) <b>90</b> yrs		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>÷</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>S. NOWAKOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>÷</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>Hosp. Records LAUREL SANITARIUM</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>470X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) <b>Pneumonia, lobar (490)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral arteriosclerosis &amp; senility</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-18-1960</b> to <b>3-18-1962</b> that (I) (we) last saw the deceased alive on <b>3-18-1962</b> and that death occurred at <b>9:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Erika P. Kraemer</b>		22b. DATE SIGNED <b>3-18-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERIKA P. KRAEMER</b>		22d. ADDRESS <b>LAUREL SANITARIUM</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 3/21/62</b>		23b. DATE THEREOF <b>3/21/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fernchiff Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Hempstead N. Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. ...</b>		25a. RECEIVED BY REGISTRAR DATE <b>MAR 20 '62</b>	
ADDRESS <b>...</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03653

## CERTIFICATE OF DEATH

03648

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1277 Brentwood Rd., NE</b>	
3. NAME OF DECEASED (Type or print) <b>Glady's E. McConville</b>		4. DATE OF DEATH Month <b>3</b> Day <b>8</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/08</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>	
11. IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Peoples Drug Store Va.</b>	
13. FATHER'S NAME <b>Fenton M. Fitzhugh</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Travers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service] <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>577-05-5063</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 301 / DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Left intraventricular hemorrhage</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis; left thoracoplasty, 1941; healed myocardial infarction; arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/2/1962</b> to <b>3/8/1962</b> that (I) (we) last saw the deceased alive on <b>3/8/1962</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>3/8/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3-12-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT FORT MYER VA</b>	23d. LOCATION (City, town or county) (State) <b>VA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 14 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlin S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

SM 9, 60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03649

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ardmore</b>			
c. LENGTH OF STAY in lb <b>D.O.A.</b>				d. STREET ADDRESS <b>Box 385</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Doris</b> Middle <b>May</b> Last <b>McDonnell</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12th</b> Year <b>1962</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1962</b>	
9. AGE (in years last birthday) <b>15</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas Francis McDonnell</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Elizabeth Osborn</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Katherine E. McDonnell, same as # 2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 4 y → X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>DUE TO</b> DUE TO <b>DUE TO</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Mar. 15, 1962</b>			
22c. NAME OF CEMETERY <b>Washington National</b>				22d. LOCATION (City, town, or country) (State) <b>Suitland, Maryland</b>			
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 15 '62</b>			
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>			

2-028360









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03656 CERTIFICATE OF DEATH 03651

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>8203 Houston Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William McGinn</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 14, 1902</b>
9. AGE (in years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius McGinn</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Rodgers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Lavenia McGinn Same as #2 (Wife)</b>	
17. INFORMANT <b>Lavenia McGinn Same as #2 (Wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastasis to Liver</b> DUE TO (c) <b>Pulmonary Edema</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 2, 1962</b> to <b>March 22, 1962</b> that (I) (we) last saw the deceased alive on <b>March 22, 1962</b> and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John Kehoe</b> M.D.		22b. DATE SIGNED <b>A.M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John Kehoe</b>		22d. ADDRESS <b>6300 Riverdale Rd., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/26/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. asch's Sons</b>		24. ADDRESS <b>Hyattsville, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAR 27 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the State Department of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03657  
03652

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>7308 C Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Bernard E. McIntire</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>5</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-13-15</u> <b>9. AGE</b> (In years last birthday) <u>47</u> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Washington, D.C.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>David McIntire</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Richardson</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>Annabelle McIntire-wife 7308-C. Street</u>	
<b>17. INFORMANT</b> <u>Annabelle McIntire-wife</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Pulmonary Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DJE TO <u>Arteriosclerotic Heart Diseases</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1, (a) <u>7</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>4 days</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 1b.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/5/62</u> <b>to</b> <u>3-5</u> <b>1962, that (I) (we) last saw the deceased alive on</b> <u>3/5/62</u> <b>and that death occurred at</b> <u>3:25 A.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>William Brainin</u> <b>M.D.</b>		<b>22b. DATE SIGNED</b> <u>3/5/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WM BRAININ</u>		<b>22d. ADDRESS</b> <u>6124 Central Ave, Capital Hill, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>3-8-62</u>		<b>23b. DATE THEREOF</b> <u>Cedar Hill Cem.</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Suitland, Md.</u>		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Lee Funeral Home, Wash D.C.</u>		<b>25. REC'D BY REGISTRAR</b> <u>7 '62</u>	
<b>25a. ADDRESS</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician, the funeral director, and the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03658

## CERTIFICATE OF DEATH

03653

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY in hospital <u>26 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2401 Montgomery Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Katherine Minors</u> First Middle Last		4. DATE OF DEATH <u>March 20</u> 19 <u>62</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1926</u> 76 yrs.
9. AGE (in years last birthday) <u>36</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance broker - Chicago, Ill</u>	
11. BIRTHPLACE County & State, or foreign country <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thermon C. Minors</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Liberman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>123-45-6789</u>	
17. INFORMANT <u>Hearts of Faith Church</u> Address <u>1234 Main St, Silver Spring, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO (b) <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>hypertension</u> DUE TO (c) <u>hypertension</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25, 1962</u> to <u>March 20, 1962</u> that (I) (we) last saw the deceased alive on <u>March 19, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thermon C. Minors</u> M.D.		22b. DATE SIGNED <u>March 20, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thermon C. Minors</u>		22d. ADDRESS <u>9301 Colverville Rd, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>3/23/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee Crematory</u>	23d. LOCATION (City, town or county) (State) <u>300 H St NE Wash D.C.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee &amp; Sons</u> ADDRESS <u>300 H St NE</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03659

03654

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Hyattsville</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASH DC</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u> d. STREET ADDRESS <u>330 Rhode Island Ave #105</u>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>RICHARD IGNATIUS MILLER</u>		<b>4. DATE OF DEATH</b> <u>MARCH 12 1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
<b>8a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PRESS MAN</u>		<b>8b. KIND OF BUSINESS OR INDUSTRY</b> <u>PRINTING SHOP</u>		<b>9. AGE</b> (In years last birthday) <u>64</u> yrs. <table border="1" style="float: right; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>10a. BIRTHPLACE</b> (County & State or foreign country) <u>Upper Marlboro Md</u>		<b>10b. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>11. FATHER'S NAME</b> <u>Henry S. Miller</u>		<b>12. MOTHER'S MAIDEN NAME</b> <u>Francis Eleanor Owings</u>									
<b>13. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>14. SOCIAL SECURITY NO.</b> <u>578-05-6976</u>		<b>15. INFORMANT</b> <u>Maud F Goddard</u> Address <u>4315 40th N Brentwood</u>							
<b>16. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>TOXEMIA</u> (b) <u>154X</u> DUE TO <u>CARCINOMATOSIS, GENERALIZED</u> (c) <u>PRIMARY CA OF RECTOSIGMOID</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)											
<b>17. INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 yrs</u> <u>3 yrs</u>											
<b>18. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>19. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)											
<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20a. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)							
<b>20d. (City or town)</b>		<b>20e. (County)</b>		<b>20f. (State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>FEB 1, 1962</u> <b>to</b> <u>MAR. 7, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>MARCH 7, 1962</u> <b>and that death occurred at</b> <u>1:30 P.M.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Luther W. Gray</u>		<b>22b. DATE SIGNED</b> <u>3/12/62</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>LUTHER W. GRAY, MD.</u>							
<b>22d. ADDRESS</b> <u>1302 18th St, N.W., WASH 6, D.C.</u>		<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3/14/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln</u>									
<b>23d. LOCATION (City, town or county)</b> <u>Colman Manor, Md.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Malloy's Funeral Home</u> <b>ADDRESS</b> <u>Mt. Rainier Md.</u>									
<b>25a. REC'D BY REGISTRAR</b> <u>MAR 15 '62</u> <b>DATE</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>John S. Frame</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and return it to the State Department of Health. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03660

03655

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beltsville Hospital</u>		d. STREET ADDRESS <u>1111 1st St. N.W.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Thomas William</u>		<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>25</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1912/12/24</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MD</u>
<b>13. FATHER'S NAME</b> <u>John Thomas</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>206-03-7015</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Anemia</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u>3</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 240, 1961</u> <b>to</b> <u>3/25/1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/24</u> <b>1962</b> , <b>and that death occurred at</b> <u>3:25 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Ernest A. Sarao</u>		<b>22b. DATE SIGNED</b> <u>3/25/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ERNEST A. SARAO</u>		<b>22d. ADDRESS</b> <u>7006 New Hampshire Ave. Takoma Park, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>March 28, 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cemetery</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Walters</u>		<b>25. REC'D BY REGISTRAR</b> <u>Arthur Walters</u>	
<b>26. REGISTRAR'S SIGNATURE</b> <u>Arthur Walters</u>		<b>27. DATE</b> <u>MAR 28 '62</u>	



**EMERGENCY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**CO-FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
5M 1/62

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03661

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03656

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Res. done before admision, a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Lanham</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>9014 Magnolia Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>RICHARD EUGENE MITCHELL</b>		4. DATE OF DEATH <b>March 24 19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 11, 46</b>	
9. AGE (In years last birthday) <b>15</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EUGENE TULLIS MITCHELL</b>		14. MOTHER'S MAIDEN NAME <b>ROSEMARY ARDIS YOUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>ROSEMARY ARDIS Mitchell</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of the skull</b> (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian struck by an automobile</b>	
20c. TIME OF INJURY Month, Day, Year <b>3/24/62</b> Hour a.m. <b>1:30 xx</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 704</b>		20f. (City or town) (County) (State) <b>Glen Arden P. G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town, or county) <b>James I. Boyd</b>	
ACTUAL SIGNATURE <b>JAMES I. BOYD</b>		DATE SIGNED <b>3/24/62</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>3/27/1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Colmar Manor, Pr. Geo. Co., Md.</b>	
22d. LOCATION (City, town, or country) <b>Fort Lincoln Cemetery Colmar Manor, Pr. Geo. Co., Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 27 '62</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Company, Riverdale, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Louis S. Krasner</b>	



03662

CERTIFICATE OF DEATH

03657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morningside</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5820 Skyline Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Elizabeth Moore</b>		4. DATE OF DEATH <b>3-17-1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 15, 1902</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Galligan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Conroy</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Ivan R. Moore</b>		Address <b>#2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the cervix</b> DUE TO <b>to undetected metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>breast carcinoma</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Breast carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Nov. 1961</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1956</b> , to <b>3/17, 1962</b> that I last saw the deceased alive on <b>3/11, 1962</b> , and that death occurred at <b>1:57 P.M.</b> from the causes and on the date stated above ADDRESS (Street city or town, state) <b>1746 K ST. N.W.</b> DATE SIGNED <b>3/17/62</b>			
ACTUAL SIGNATURE <b>Edward J. Pacious M.D.</b>		1746 K St., NW Washington, D.C.	
PHYSICIAN'S NAME (Type) <b>Edward J. Pacious</b>		1746 K St., NW Washington, D.C.	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/21/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jas. T. Ryan, Inc. by G. T. Ryan</b>		24. REGISTRAR'S SIGNATURE <b>SE. Wash. D.C. 317 Pa. Ave</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. VS AND (4) 15M 9/58

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03663  
03658  
CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-1</b> d. STREET ADDRESS <b>1441 Newton Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Jessie Mae Moran</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>27</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Aug. 31, 1891</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Chantilly, Virginia</b>
<b>13. FATHER'S NAME</b> <b>James Milton Moran</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Flora Virginia Moran</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>260 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1. Massive Cerebral Hemorrhage (Lt. Temporo-Occipital lobe)</b> <b>2. Diabetes Mellitus</b> <b>3. Hypertensive arteriosclerosis heart disease</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>19</b> Month, Day, Year p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>March 27, 1962</b> , to <b>March 27, 1962</b> , that (I) <b>X</b> last saw the deceased alive on <b>March 27, 1962</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>T. H. Bergemann</b>		<b>22b. DATE SIGNED</b> <b>3-27-1962</b>	<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Teil Bergemann</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal-Burial</b>		<b>23b. DATE THEREOF</b> <b>3-30-62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>McGullock Cemetery, Sterling, Virginia</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. Berkley Green</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Herndon, Virginia</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE MAR 29 '62</b>



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03664

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03659

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY (In 1b)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Prince George's

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Bladensburg

d. STREET ADDRESS

5504 Tilden Road

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED  
(Type or print)

Prince George's General Hospital

First

Middle

Last

Bertha

Morrison

4. DATE OF DEATH

Month

Day

Year

March

26,

19 62

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

March 1, 1879

9. AGE (In years last birthday)

83 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Thomas Smyth Odell

14. MOTHER'S MAIDEN NAME

Mary Banda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

No

James Harry Morrison, same as # 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

442X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Cerebrovascular accident

Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3/26/62

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/30/62

22c. NAME OF CEMETERY OR CREMATORY

Maple Hill Cemetery

22d. LOCATION (City, town, or county)

Plainfield Indiana

(State)

23. FUNERAL DIRECTOR

W. W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR

DATE MAR 29 1962

24b. REGISTRAR'S SIGNATURE

Charles L. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03660

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>3 Hrs. 5 Min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5123 Crittenden Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Maude</u> Middle <u>pearl</u> Last <u>Mullikin</u>		<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>12</u> Year <u>19 62</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 18, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>					
<b>13. FATHER'S NAME</b> <u>Edward Whittington</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Ford</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> <u>Curtis E. Mullikin Same as #2 (son)</u> Address <u>  </u>							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 420.0 DUE TO (b) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Arteriosclerosis Heart Disease</u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a):</b>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/12</u> <b>19</b> <u>62</u> <b>to</b> <u>3/12</u> <b>19</b> <u>62</u> <b>and that (I) (we) last saw the deceased alive on</b> <u>3/12</u> <b>19</b> <u>62</u> <b>and that death occurred at</b> <u>8:30</u> <b>M.</b> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Barry Rosenberg</u> <b>M.D.</b>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Barry Rosenberg</u>						<b>22d. ADDRESS</b> <u>1210 Chillum Manor Rd., West Hyattsville, Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/15/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln</u>		<b>23d. LOCATION</b> (City, town or county) <u>Colmar Manor,</u>		<b>(State)</b> <u>Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis Gasch's Sons</u>						<b>ADDRESS</b> <u>Hyattsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAR 15 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03666

03661

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>College Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5100 Bernyn Blvd</i>		d. STREET ADDRESS <i>15100 Bernyn Road</i>	
3. NAME OF DECEASED (Type or print) <i>HELEN</i> First <i>LOUISE</i> Middle <i>NEITZEY</i> Last		4. DATE OF DEATH <i>Mar 10</i> Month <i>1966</i> Day Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC 18, 1936</i>
9. AGE (In years last birthday) <i>25</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Analyst</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Commerce Dept</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Walter N. Neitzey</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>unknown</i>	
17. INFORMANT <i>Mrs Dorothy Neitzey</i> Address <i>Same as #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Dyslipneumonia, Hodgkin's type, cervical nodes, metastasis to chest &amp; lungs</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>200</i> (c) <i>200</i> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 1960</i> to <i>Mar 1966</i> , that (I) (we) last saw the deceased alive on <i>MAR 9 1966</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W. C. Etienne</i> M.D.		22b. DATE SIGNED <i>3/19/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. C. ETIENNE</i>		22d. ADDRESS <i>4713 Bernyn Rd College Park</i>	
23a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-13-66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Washington Mem. Park</i>		23d. LOCATION (City, town, or county) (State) <i>W. Hyattsville, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers, Revdale</i> ADDRESS		25a. REC'D BY REGISTRAR <i>W. W. Chambers</i> DATE <i>MAR 14 '66</i>	
25b. REGISTRAR'S SIGNATURE <i>C. W. S. Hume</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain calm. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03667

Item 9 Film 4311 4/12/62 mh

CERTIFICATE OF DEATH

03662

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>7 hours</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>70 College Park</b> d. STREET ADDRESS <b>5500 Richmond Avenue, Lakeland</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James Garfield Nickens</b>		4. DATE OF DEATH Month Day Year <b>March 30 19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED XX</b>		8. DATE OF BIRTH <b>5-21-1899</b>	
9. AGE (In years last birthday) <b>62.68</b> yrs		10. IF UNDER 1 YEAR Months Days <b>62.68</b>	
11. IF UNDER 24 HRS. Hours Min <b>62.68</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Nickens</b>		14. MOTHER'S MAIDEN NAME <b>Lula Webb</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>David Nickens</b>	
17. INFORMANT <b>David Nickens</b>		Address <b>4001 Hampden St., Kensington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 28645 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Malnutrition, dehydration</b> (c) <b>Malnutrition, dehydration</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>10 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-29</b> to <b>3-30</b> , 1962, that (I) (we) last saw the deceased alive on <b>3-30</b> , 1962, and that death occurred at <b>6:45</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin S. Pecson</b>		22b. DATE SIGNED <b>APR 6 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Benjamin S. Pecson</b>		22d. ADDRESS <b>7028 Marlboro Pike, District Hgts., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		25a. REC'D BY REGISTRAR <b>APR 6 1962</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. DATE <b>APR 6 1962</b>	



# CERTIFICATE OF DEATH

03663

1. PLACE OF DEATH a. COUNTY <b>Prince George County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		c. LENGTH OF STAY IN 1b <b>19 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		d. STREET ADDRESS <b>1800 Brooklyn Bridge Rd., Laurel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1800 Brooklyn Bridge Rd. Laurel, Maryland</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM ALBERT NORTHROP</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>March 29 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/06</b>	
9. AGE (In years lost birthday) <b>55 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		11. BIRTHPLACE (State or foreign country) <b>Ashland, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Northrup</b>		14. MOTHER'S MAIDEN NAME <b>Anne Cope</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>577-01-8792</b>	
17. INFORMANT <b>Wife-</b>		Address <b>1800 Brooklyn Bridge Rd. Laurel, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion 24 years</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>177/200 - myocardial infarction - 3 yrs</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21. I certify that (I) (the hospital) attended the deceased from <b>10-15-1959</b> to <b>3/29-1962</b> , that (I) (we) last saw the deceased alive on <b>3/27-1962</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>N B STEWARD</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b></b>			
22c. PHYSICIAN'S NAME (Type) <b>N B STEWARD</b>		22d. ADDRESS <b>314 Compman Laurel Md</b>		23a. REC'D BY REGISTRAR <b>APR 3 '62</b>		23b. REGISTRAR'S SIGNATURE <b>Arthur J. Steward</b>	
23c. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23d. DATE THEREOF <b>Mar 31, 1962</b>		23e. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEM</b>		23f. LOCATION (City, town, or county) (State) <b>PRINCE GEORGE CO., MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Steward</b>		ADDRESS <b>254 CARROLL ST. WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>APR 3 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Steward</b>	



CERTIFICATE OF DEATH

03669

03664

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural (Hyattsville)</u> c. LENGTH OF STAY IN TB <u>3 yrs 3 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paint Branch Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>PRINCE GEORGES.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5606 31<sup>st</sup> Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>WILHELMINA NONE NORUELL</u>		<b>4. DATE OF DEATH</b> Month <u>MAR</u> Day <u>15</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>AUG 17, 1873</u>	
<b>9. AGE</b> (In years last birthday) <u>88</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Lenaconing Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA.</u>	
<b>13. FATHER'S NAME</b> <u>Henry Milford</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Schaidt</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT</b> <u>James Norvell</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>acute massive gastric hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - generalized</u> (c) <u>Arteriosclerosis CVD.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-2</u> <b>1955</b> <b>to</b> <u>3-15</u> <b>1962</b> <b>that (I) (we) last saw the deceased alive on</b> <u>3-8</u> <b>1962</b> <b>and that death occurred</b> <u>7:30 AM</u> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>R.D. Baker M.D.</u> <b>22b. DATE SIGNED</b> <u>3-15-62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>R.D. Baker, M.D.</u>		<b>22d. ADDRESS</b> <u>2513 Bucklough Rd. Bethesda, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/17/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Stenwood Cent</u>		<b>23d. LOCATION</b> (City, town or county) <u>Wash. D. C.</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lees</u>		<b>25a. REC'D BY REGISTRAR</b> <u>March 19 1962</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



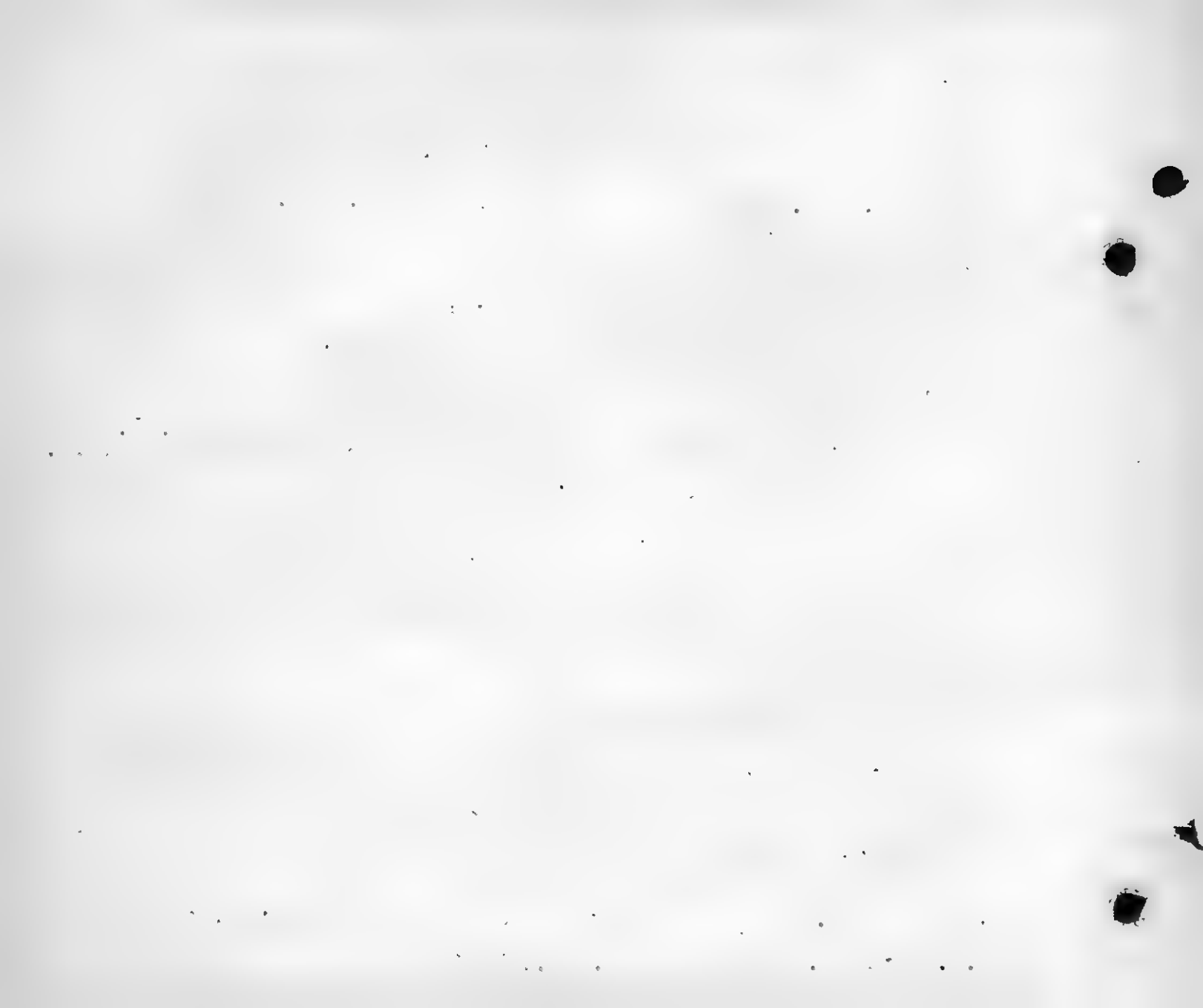
03670

# CERTIFICATE OF DEATH

Reg. Dist. No. 03665

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7111 Dist. Hgts. Parkway</u>		d. STREET ADDRESS <u>7111 Dist. Hgts. Pkway</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Beatrice</u> First Middle Last <u>O'Neil</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4, 1898</u>
9. AGE (In years lost birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward White</u>		14. MOTHER'S MAIDEN NAME <u>Jean Courtney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Eugene O'Neil, Jr.</u>		Address <u>5957 23rd. Pl., SE Washington 21, D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1962</u> to <u>March 5, 1962</u> that I last saw the deceased alive on <u>March 5, 1962</u> and that death occurred at <u>2:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>BENJAMIN S. PEESON</u> M.D.		ADDRESS (Street, city or town, state) <u>7078 Morebno Pike WASH. 28. D.C.</u>	
DATE SIGNED <u>3-5-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/8/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jas. T. Ryan, Inc.</u>		ADDRESS <u>317 Pa. Ave., SEDCO</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. R. R.</u>	

I





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03671

03666

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chaverly</u> c. LENGTH OF STAY IN 1b <u>3 Hrs. 8 Min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u> d. STREET ADDRESS <u>Box 2768</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>#1 Baby Boy</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <u>March 3</u> 19 <u>62</u> 8. DATE OF BIRTH <u>March 3, 1962</u> 9. AGE (In years last birthday) <u>3</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>8</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Ind</u> <b>12. CITIZEN OF WHAT COUNTRY?</b>		<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Thelma Aretta Norfolk Perrie</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mother</u> Address <u>Same as above</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 30-34 weeks gestation</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3-3</u> <b>1962, to</b> <u>3-3</u> <b>1962, that (I) (we) last saw the deceased alive on</b> <u>3-3</u> <b>19 62, and that death occurred at</b> <u>11:50</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Dr. Robert Sasscer</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. Robert Sasscer</u> <b>22d. ADDRESS</b> <u>R.F.D. Box 2150, Upper Marlboro, Maryland</u> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>23b. DATE THEREOF</b> <u>3-17-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Prince Geo. Gen. Hospital</u> <b>23d. LOCATION (City, town or county)</b> <u>Cheverly, Maryland</u> <b>(State)</b> _____			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Harry W. Penn, Jr. Adm.</u> <b>25a. REC'D BY REGISTRAR</b> <u>MAR 21 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>James S. Thomas</u>			

2-027863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03672

CERTIFICATE OF DEATH

03667

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>3 Hrs. 9 Mins</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 2768</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>#2 Baby Boy</b> f. SEX <b>Male</b> g. COLOR OR RACE <b>White</b> h. NEVER MARRIED <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> i. WIDOWED <input type="checkbox"/> j. DIVORCED <input type="checkbox"/> k. DATE OF BIRTH <b>March 3, 1962</b> l. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) Months Days Hours Min. <b>3 9</b>		4. DATE OF DEATH <b>March 3, 1962</b> m. BIRTHPLACE (County & State, or foreign country) <b>Md</b> n. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Thelma Aretta Norfolk Perrie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mother</b> <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause on line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - 22-24 wks gestation</b> 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-3</b> 19 <b>62</b> to <b>3-3</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-3</b> 19 <b>62</b> , and that death occurred at <b>11:15</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Robert Sasscer</b> 22b. DATE SIGNED <b>3-3-62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert Sasscer</b> 22d. ADDRESS <b>R.F.D. Box 2150, Upper Marlboro, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b> 23b. DATE THEREOF <b>3-16-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Prince George's Gen. Hospital Cheverly, Maryland</b> 23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr., Administrator</b> 25a. REC'D BY REGISTRAR <b>MAR 21 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Harry W. Penn, Jr.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH

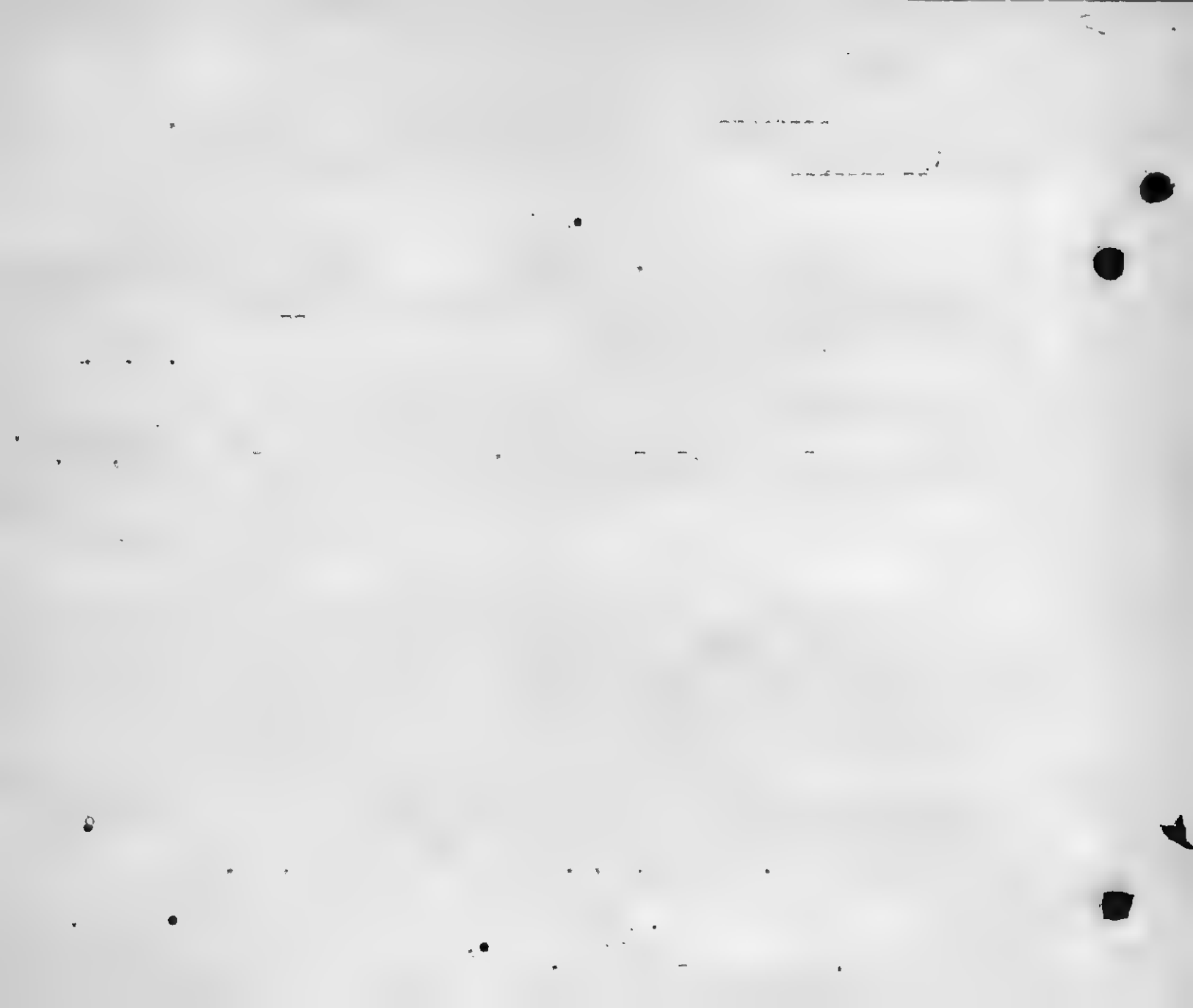
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03673

03668

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 2768</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Theima A. Perrie</b> 4. DATE OF DEATH <b>March 4 1962</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>June 29 1918</b> 9. AGE (In years last birthday) <b>44</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tobacco Farming</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Mervin Norfolk</b> 14. MOTHER'S MAIDEN NAME <b>Bertha Eleanor Norfolk</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>579-52-6075</b> 17. INFORMANT <b>Mrs. Eleanor Rollins-Greenbelt, Md.</b> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio sclerosis of the heart</b> DUE TO <b>Arterio sclerosis of the heart</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Unknown</b> DUE TO <b>Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pregnancy</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Pregnancy</b> 20c. TIME OF INJURY Month, Day, Year <b>June 1962</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. [City or town] (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1962</b> to <b>Mar 3 1962</b> that (I) (we) last saw the deceased alive on <b>3 Mar 1962</b> and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert B. Sasscer, M.D.</b> 22c. PHYSICIAN'S NAME (Type) <b>Robert B. Sasscer, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>3/4/62</b> 22d. ADDRESS <b>Upper Marlboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>3/7/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Upper Marlboro Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home - Md.</b> 25. REC'D BY REGISTRAR <b>MAR 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>	



03674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03669

FOR WHITE  
HEALTH DEPT.

1. PLACE OF DEATH  
a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN, if outside of corporate limits, write RURAL and give nearest town

c. LENGTH OF STAY IN It

Riverdale

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

DOA Leland Memorial Hospital

3. NAME OF DECEASED  
(Type or print)

ABNEY

GLENN

PERRY

5. SEX

Male

White

WIDOWED

DIVORCED

November 27, 27

34

March

23

19 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

Kelly Motor Lines

Mississippi

13. FATHER'S NAME

ERMON

PERRY

MYRTLE

ARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

Yes

W.W. II

UNKNOWN

Billy Perry

73 Water Witch, New Jersey

Highland, New Jersey

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO

Fracture of the skull, crushed chest compound fracture of the right hip

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Pedestrian struck by an automobile

20c. TIME OF INJURY  
Hour XXX

Month, Day, Year

8:50 p.m.

3/23

19 62

20d. INJURY OCCURRED

While working ☒ Not While working ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Route # 1

Laurel

P. G.

Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD

M.D.

ASS STANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

3/24/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3-27-62

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

Sumter S. Carolina

23. FUNERAL DIRECTOR

W. W. Chambers & Co

ADDRESS

Riverdale Md

24a. REC'D BY REGISTRAR

MAR 27 '62

24b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any documents necessary, Pages 1, 2, and 3 to the funeral director. Page 4 to the State Department of Health. Page 5 to the State Department of Health. Page 6 to the State Department of Health. Page 7 to the State Department of Health. Page 8 to the State Department of Health. Page 9 to the State Department of Health. Page 10 to the State Department of Health. Page 11 to the State Department of Health. Page 12 to the State Department of Health. Page 13 to the State Department of Health. Page 14 to the State Department of Health. Page 15 to the State Department of Health. Page 16 to the State Department of Health. Page 17 to the State Department of Health. Page 18 to the State Department of Health. Page 19 to the State Department of Health. Page 20 to the State Department of Health. Page 21 to the State Department of Health. Page 22 to the State Department of Health. Page 23 to the State Department of Health. Page 24 to the State Department of Health. Page 25 to the State Department of Health. Page 26 to the State Department of Health. Page 27 to the State Department of Health. Page 28 to the State Department of Health. Page 29 to the State Department of Health. Page 30 to the State Department of Health. Page 31 to the State Department of Health. Page 32 to the State Department of Health. Page 33 to the State Department of Health. Page 34 to the State Department of Health. Page 35 to the State Department of Health. Page 36 to the State Department of Health. Page 37 to the State Department of Health. Page 38 to the State Department of Health. Page 39 to the State Department of Health. Page 40 to the State Department of Health. Page 41 to the State Department of Health. Page 42 to the State Department of Health. Page 43 to the State Department of Health. Page 44 to the State Department of Health. Page 45 to the State Department of Health. Page 46 to the State Department of Health. Page 47 to the State Department of Health. Page 48 to the State Department of Health. Page 49 to the State Department of Health. Page 50 to the State Department of Health. Page 51 to the State Department of Health. Page 52 to the State Department of Health. Page 53 to the State Department of Health. Page 54 to the State Department of Health. Page 55 to the State Department of Health. Page 56 to the State Department of Health. Page 57 to the State Department of Health. Page 58 to the State Department of Health. Page 59 to the State Department of Health. Page 60 to the State Department of Health. Page 61 to the State Department of Health. Page 62 to the State Department of Health. Page 63 to the State Department of Health. Page 64 to the State Department of Health. Page 65 to the State Department of Health. Page 66 to the State Department of Health. Page 67 to the State Department of Health. Page 68 to the State Department of Health. Page 69 to the State Department of Health. Page 70 to the State Department of Health. Page 71 to the State Department of Health. Page 72 to the State Department of Health. Page 73 to the State Department of Health. Page 74 to the State Department of Health. Page 75 to the State Department of Health. Page 76 to the State Department of Health. Page 77 to the State Department of Health. Page 78 to the State Department of Health. Page 79 to the State Department of Health. Page 80 to the State Department of Health. Page 81 to the State Department of Health. Page 82 to the State Department of Health. Page 83 to the State Department of Health. Page 84 to the State Department of Health. Page 85 to the State Department of Health. Page 86 to the State Department of Health. Page 87 to the State Department of Health. Page 88 to the State Department of Health. Page 89 to the State Department of Health. Page 90 to the State Department of Health. Page 91 to the State Department of Health. Page 92 to the State Department of Health. Page 93 to the State Department of Health. Page 94 to the State Department of Health. Page 95 to the State Department of Health. Page 96 to the State Department of Health. Page 97 to the State Department of Health. Page 98 to the State Department of Health. Page 99 to the State Department of Health. Page 100 to the State Department of Health.





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03675

Item 9 Film U310 4/2/62 mh

03670

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b> c. LENGTH OF STAY IN TB <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>46 Brentwood</b> d. STREET ADDRESS <b>3712 Taylor Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edgar M. Poole, Sr.</b>		4. DATE OF DEATH Month Day Year <b>March 23 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 18, 1886</b>
9. AGE (In years last birthday) <b>76 77 yrs.</b>		10. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Warner S Poole</b>		14. MOTHER'S MAIDEN NAME <b>Ella Orme</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>578 22 7988A</b>	
17. INFORMANT <b>Edgar M Poole Jr Brentwood Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>Congestive Heart Failure</b> <b>Myocardial Fibrosis</b> <b>Coronary Arteriosclerotic Heart Disease</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>days</b> <b>years</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> to <b>3-23</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-23</b> , 19 <b>62</b> , and that death occurred at <b>4:05</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>		22b. DATE SIGNED <b>3/25/62</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS <b>6311 Balto. Ave - Riverdale, Ind</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 26, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 29 '62</b>	
ADDRESS <b>Hyattsville Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03672

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY in lb <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>7433 Parkwood Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary M. Pugh</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>2</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-22-01</b>	
<b>9. AGE</b> (In years last birthday) <b>60 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Dept. Store</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>John Mulloly</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Lynch</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217 10 7861</b>	
<b>17. INFORMANT</b> <b>William M. McGinnis Same as #2 (Son)</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Carcinoma of the rectum</b> (c) <b>141,</b> <b>2 yrs.</b> DUE TO cause last. (c)			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from... 2/12 ... 1962 to ... 2/13 ... 1962 that (I) (we) last saw the deceased alive on... 2/6 ... 1962 and that death occurred at... 2:55 P.M. ... from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>John Kehoe M.D.</b>		<b>22b. DATE SIGNED</b> <b>2:55 P.M.</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Dr. John Kehoe</b>		<b>22d. ADDRESS</b> <b>6300 Riverdale Road, Riverdale, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/5/62</b>	
<b>23c. NAME OF CEMETERY OR</b> <b>Gate of Heaven</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Wheaton Md</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis Hachi Sono</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 7 '62</b>	
<b>ADDRESS</b> <b>Hyattsville, Md.</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanks</b>	

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03678  
03673

1. PLACE OF DEATH a. COUNTY Prince George's County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Hyattsville b. COUNTY PG County	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly Maryland		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 5403 37th Ave.	
c. LENGTH OF STAY IN 1b 14 days		d. STREET ADDRESS Hyattsville Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle C. Last Reeves		4. DATE OF DEATH Month 3 Day 20 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Plate Printer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James C. Reeves		14. MOTHER'S MAIDEN NAME Mary A. Fraser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-12-9092A	
17. INFORMANT James C. Reeves		Address 9700 Riggs Rd. Adelphi, Md. (son)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.2 DUE TO Conditions, if any (b) gave rise to immediate cause (c), stating the underlying cause last DUE TO Arteriosclerosis Obstructive Disease		INTERVAL BETWEEN ONSET AND DEATH 3 hr. 15 yrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-17-62 to 3-20-62, that (I) (we) last saw the deceased alive on 3-20-62, and that death occurred at 9:50 PM, from the causes and on the date stated above.			
22a. SIGNATURE R. D. Bauer M.D.		22b. DATE SIGNED 3-20-62	
22c. PHYSICIAN'S NAME (Type) R. D. Bauer M.D.		22d. ADDRESS 2513 One Bridge Road Adelphi, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/62	
23c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill		23d. LOCATION (City, town or county) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE C. C. S. Kline	
ADDRESS Hyattsville, Md.		DATE MAR 27 '62	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

03679

CERTIFICATE OF DEATH

Reg. Dist. No. 03674

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1962</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4010-29th Street</u>		d. STREET ADDRESS <u>4010-29th Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Marlene</u> Last <u>Richards</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4, 1868</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edward A. Richards</u>		Address <u>(Address same as above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1956</u> to <u>March 31, 1962</u> that I last saw the deceased alive on <u>March 30, 1962</u> and that death occurred at <u>5:05 PM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Richard L. Whelton</u> M.D. <u>1021 University Blvd</u>		<u>3-31-62</u>	
PHYSICIAN'S NAME (Type) <u>Richard L. Whelton</u>		<u>Silver Spring Md</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/3/1962</u>	<u>Ft. Lincoln</u>	<u>Colmar Manor Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		24. REC'D BY REGISTRAR <u>Dr. L. S. Koss</u>	
ADDRESS <u>Mt. Rainier Md.</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>APR 4 '62</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FURNEL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and at any event within 72 hours after death.

VR A15ME  
SM 4/62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03680

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03675

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>	
c. LENGTH OF STAY IN b.		d. STREET ADDRESS <b>Ardmore Road, Box 263</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert Byrd Ridgeway</b>		4. DATE OF DEATH <b>March 14, 1962</b>	
5. SEX <b>Male</b>		6. CO. OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1882</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>14</b> Hours <b>14</b> Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Ridgeway</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Thompson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Lucille Ridgeway</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO (b) <b>CORONARY THROMBOSIS</b> DUE TO (c) <b>Coronary Thrombosis</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b>3</b> Day <b>17</b> Year <b>1962</b> 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3/14/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>3-17-62</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Cemetery</b> 22d. LOCATION (City, town, or country) (State) <b>Forestville, Maryland</b>			
23. FUNERAL DIRECTOR <b>W. W. Chambers Co. Riverdale, Md</b> 24a. REC'D BY REGISTRAR <b>19 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Fraw</b>			



03681

## CERTIFICATE OF DEATH

03676

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Prince George</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale</b>		c LENGTH OF STAY IN 1b <b>X Glenn Dale</b>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Telegraph Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Riedel</b> Last <b>Riedel</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>7</b> Year <b>1962</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/26/82</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Ellwein</b>		14. MOTHER'S MAIDEN NAME <b>Christina Dockler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
INFORMANT Address <b>Jacob F. Riedel same as #2 (Husband)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Artery Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Year</b> <b>2 Years</b> <b>3 Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>CVA - Rthrombolgia 2/16/53.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1953</b> to <b>Mar 7, 1962</b> , that I lost saw the deceased alive on <b>Mar 3, 1962</b> , and that death occurred on <b>Mar 7, 1962</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H James Riedel</b>		DATE SIGNED <b>3/7/62</b>	
PHYSICIAN'S NAME (Type) <b>H James Riedel</b>		M.D. <b>RFD Glenn Dale Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/9/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Church</b>	22d. LOCATION (City, town, or county) (State) <b>Bowie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>Mar 9 '62</b>		24b. REGISTRAR'S SIGNATURE <b>C. R. Riedel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58









03633

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN ID <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		d. STREET ADDRESS <b>7112 Allison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EULA E. RUTLEDGE</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>MARCH 15 19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-20-1896</b>		9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>66</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Albert E. Rutledge</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret A. Causey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Clifton E. Causey Same as #2 (Brother)</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Right Intracerebral Hemorrhage</b> DUE TO (b) <b>Hypertensive Arteriosclerotic Heart Disease</b> DUE TO (c) <b>9 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>9 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a). <b>no</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>no</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>no</b>		20f. (City or town) <b>no</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/14/62</b> to <b>3/15/62</b> , that (I) (we) last saw the deceased alive on <b>3/14/62</b> , and that death occurred at <b>8:05 A.M.</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>F. E. Musser</b>		22b. DATE SIGNED <b>3/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. E. Musser</b>		22d. ADDRESS <b>441024 - ana Landover Hills</b>		22e. M.D. <b>no</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/17/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City, town or county) <b>Colmar Manor,</b>		23e. (State) <b>Md.</b>		23f. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>	
23g. ADDRESS <b>Hyattsville, Md.</b>		23h. REC'D BY REGISTRAR DATE <b>MAR 19 '62</b>		23i. REGISTRAR'S SIGNATURE <b>Clifton E. Causey</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

03684

03679

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> c. LENGTH OF STAY IN It <u>adm. 3-14-1956</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAUREL SANITARIUM</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> d. STREET ADDRESS <u>4801 CARVER STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>GUSTAVIA - VIOLA - RYAN</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>3 20 1962</u> Month Day Year	
<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>MAY 6 - 1896</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years, last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>APONZA</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>KATE V. FRYE</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>216 40 6476</u> <b>17. INFORMANT</b> <u>Hosp. Records LAUREL SANITARIUM</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>General Atherosclerosis &amp; dementia (334)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>(334)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>arteriosclerosis heart disease</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <u>19</u> <b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20d. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from...</b> <u>June</u> <u>1956</u> to <u>MARCH 20, 1962</u> that (I) (we) last saw the deceased alive on <u>MARCH 20, 1962</u> and that death occurred at <u>5:12 M.</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Erika P. Kraemer</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>ERIKA P. KRAEMER</u>		<b>22b. DATE SIGNED</b> <u>3-20-62</u> <b>22d. ADDRESS</b> <u>LAUREL SANITARIUM LAUREL Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>3/22/62</u>		<b>23c. NAME OF CEMETERY OR CEMETERY</b> <u>Epithany Episcopal Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Forestville, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Dorsch's Sons</u> <u>Hyattsville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 27 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>W. S. HARRIS</u>	

(M)

(I)

MEDICAL CERTIFICATION



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 is retained for your use. The State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03680

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5643 Shadyside Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 5643 Shadyside Avenue	
3. NAME OF DECEASED (Type or print) CHESTER ROSS RYON 4. DATE OF DEATH March 13 1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 25, 1902 60 yrs		9. AGE (In years last birthday) 60 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sightseeing-Hacker 11. BIRTHPLACE (State or foreign country) Washington, D.C. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROSS WILLIAM RYON 14. MOTHER'S MAIDEN NAME HARRIET ANN SUMMERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W.II 16. SOCIAL SECURITY NO 579-16-4701 17. INFORMANT Roger William Conway, Jr. University Hills, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Conditions, if any, which gave rise to immediate cause (b) Acute Carbon monoxide poisoning (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Ran hose from exhaust into car 20c. TIME OF INJURY Month, Day, Year 6:20 p.m. 3-13-62 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Parked Car 20f. (City or town) Suitland P.G. Md		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3-19-62 22c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery 22d. LOCATION (City, town, or county) Arlington, Virginia 23. FUNERAL DIRECTOR W. W. Chambers & Co Riverdale, Md 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur L. Hume		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/14/62	



1  
FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03681

1. PLACE OF DEATH  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Foote Transient  
c. LENGTH OF STAY IN 1b Congress Heights  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Webster's Boat Yard 809 Portland Street S. E.  
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before and since on)  
a. STATE District of Columbia  
b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
3. NAME OF DECEASED (Type or print) Irving Leroy Sandy Jr  
4. DATE OF DEATH March 24 19 62  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH May 25, 1937 9. AGE (In years last birthday) 24 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.  
13. FATHER'S NAME Irving Leroy Sandy Sr. 14. MOTHER'S MAIDEN NAME Lillian Mae Violet  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes 56-57 16. SOCIAL SECURITY NO 577-52-8537 17. INFORMANT Michele Kathleen Sandy, same as # 2  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Asphyxia  
850X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Drowning  
(a), stating the underlying cause last. DUE TO  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒  
20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a boat into the river  
20c. TIME OF INJURY Month, Day, Year 10:55am 3/24/19 62 20d. INJURY OCCURRED While ☐ Not While ☒ at work ☐ at work ☒  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River Fort Foote P. G. Md  
20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ 3/24/62  
Address (Street, city, town, or county)  
ACTUAL SIGNATURE James I. Boyd M.D. DATE SIGNED  
EXAMINER'S NAME (Type) James I. Boyd  
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3/28-1962 22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL 22d. LOCATION (City, town, or country) Ft. Myer, Va  
23. FUNERAL DIRECTOR W.W. CHAMBERS Co 517-11 1/2 St SE WASH DC 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas  
DATE MAR 29 '62





**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any corrections are necessary, these execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03682

**1. PLACE OF DEATH**  
a. COUNTY Prince George's MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Riverdale  
c. LENGTH OF STAY IN b.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Prince Georges  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel  
d. STREET ADDRESS 35 A Street  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print) ANDREW SAFFELL SEALOCK  
Fist Middle Last  
**4. DATE OF DEATH** March 9, 1962  
Month Day Year  
9 AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  
yrs Months Days Hours Min.

**5. SEX** Male **6. COLOR OR RACE** White **7. MARRIED** ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
**8. DATE OF BIRTH** June 29, 1898 **9. BIRTHPLACE** (State or foreign country) Virginia U.S.A.  
**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Boiler Tender **10b. KIND OF BUSINESS OR INDUSTRY** Mineral Pigments **11. CITIZEN OF WHAT COUNTRY?**

**12. FATHER'S NAME** Dorsey Sealock **13. MOTHER'S MAIDEN NAME** Martha Kearns  
**14. WAS DECEASED EVER IN U.S. ARMED FORCES?** No **15. SOCIAL SECURITY NO.** None **16. INFORMANT** Mrs. Stella M. Sealock, Address 35 A Street Laurel, Maryland  
**17. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and Shock  
(b) Gunshot wound in the head  
(c) DUE TO  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last:  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

**20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.** Shot self through head  
**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)  
**20c. TIME OF INJURY** Hour 3:43 p.m. Month Mar. 9, 1962 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☒ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) In Auto **20f. (City or town)** Laurel, Prince Geo. Cty., Md. (County) (State)

**21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐**

**ACTUAL SIGNATURE** James I. Boyd **CHIEF MEDICAL EXAMINER** ☐  
**EXAMINER'S NAME (Type)** JAMES I. BOYD, M.D. **ASSISTANT MEDICAL EXAMINER** ☐  
**DEPUTY MEDICAL EXAMINER** ☒ **DATE SIGNED** 3/9/62.  
**Address (Street, city, town, or county)** 254 Carroll St N.W. DC  
**22a. BURIAL, CREMATION, REMOVAL (Specify)** Burial **22b. DATE THEREOF** 3/12/62 **22c. NAME OF CEMETERY OR CREMATORY** Hill Cemetery **22d. LOCATION** (City, town, or country) (State) LAUREL, PRINCE GEORGES CO., MD.  
**23. FUNERAL DIRECTOR** Arthur E. Thomas **24a. REC'D BY REGISTRAR** MAR 14 '62 **24b. REGISTRAR'S SIGNATURE**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
03688  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
03683

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SUITLAND c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3218 Sycamore ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Md. b. COUNTY P. G. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Suitland d. STREET ADDRESS 3218 Sycamore ave e. DATE OF DEATH 3-9-62 1962	
3. NAME OF DECEASED (Type or print) Austin First Middle Last 4. DATE OF DEATH 3-9-62 1962		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 11 - 1902 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.G. 10b. KIND OF BUSINESS OR INDUSTRY Clerk 11. BIRTHPLACE (County & State, or foreign country) Mass 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Justin Shaw 14. MOTHER'S MAIDEN NAME Elizabeth Nickerson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 577-20-0195 17. INFORMANT d. Madeline Hayden Address 3218 Sycamore ave, Suitland Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 116X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) coronary arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Jan 5 to Jan 8, 1962, and that death occurred at Mar 9, 1962, from the causes and on the date stated above. 22a. SIGNATURE J. M. Lee 22c. PHYSICIAN'S NAME (Type) J. M. Lee & Sons 22d. ADDRESS 300 H St NE 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED Mar 9 62		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3-12-62 23c. NAME OF CEMETERY OR CREMATORY Arlington Hall Cem. Arlington Va. 23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. M. Lee & Sons 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		25c. DATE MAR 11 62 25d. SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03689

## CERTIFICATE OF DEATH

Reg. Dist. No. 03684

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Avondale, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>14 yrs. 11 mo.</b>		d. STREET ADDRESS <b>2013 Hayden Road, N.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>A</b> Last <b>Shea</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1864</b>
9. AGE (In years last birthday) <b>98</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Rooney</b>		14. MOTHER'S MAIDEN NAME <b>Ann Agnes Atkinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Sacred Heart Home, W. Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4</b> <b>X</b> <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Cardiac Hypertension</b> (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6:27 am</b> <b>6/27/62</b> to <b>6:27 am</b> <b>6/27/62</b> , that I last saw the deceased alive on <b>6/27/62</b> , and that death occurred at <b>6:27 am</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William C. Hulse</b> M.D.		DATE SIGNED <b>3/2/62</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-6-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b>		ADDRESS <b>3821-14th St N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>3/2/62</b>		24b. REGISTRAR'S SIGNATURE <b>S. J.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. Page 6 may be retained by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03690 CERTIFICATE OF DEATH 03685

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>44E D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Point Park Nursing Home</u>		d. STREET ADDRESS <u>539 1st St. N.W., S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Erta</u> Middle <u>Lucas</u> Last <u>Shipman</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1924</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Nursing Home</u>		Address <u>Adelphi</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchial</u> 401X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes Mellitus</u> (c) DUE TO cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 15, 1962</u> to <u>March 21, 1962</u> that (I) (we) last saw the deceased alive on <u>March 18, 1962</u> , and that death occurred at <u>20M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Stuart L. Nelson</u>		22b. DATE SIGNED <u>3-21-62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>March 24, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Walker Chapel Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Gray</u>		25a. REC'D BY REGISTRAR <u>March 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Erta Shipman</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon bars. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03691 CERTIFICATE OF DEATH 03687

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>31 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Baden</b> d. STREET ADDRESS <b>P.O. Baden</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas E. Simms</b>		4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1896</b>	
9. AGE (In years last birthday) <b>66</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b>	
11. IF UNDER 24 HRS. Hours <b>6</b> M. n. <b>5</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Prince George, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>J. William Simms</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Gray</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>Josephine Simms</b>		17. INFORMANT <b>Brandywine, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4 20</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Fibrosis</b> DUE TO (c) <b>Coronary Arteriosclerotic Heart Disease</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. [City or town] [County] [State]	
21. I certify that (I) (this hospital) attended the deceased from <b>2-27</b> , 19 <b>62</b> to <b>3-30</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>3-30</b> , 19 <b>62</b> , and that death occurred at <b>10:00</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>David S. Clayman</b> M.D.		22b. DATE <b>3/30/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. David S. Clayman</b>		22d. ADDRESS <b>6311 Baltimore Ave., Riverdale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter</b>		23d. LOCATION (City, town or county) (State) <b>Waldore Chr. County Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George S. Nelson</b>		25a. REC'D BY REGISTRAR <b>APR 6 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>		25c. DATE <b>3/31/62</b>	



may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03692

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03689

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PRINCE GEO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUITLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 DUVALL ST</b>		d. STREET ADDRESS <b>17 DUVALL ST</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>LILLIE ELLEN SITES</b>		4. DATE OF DEATH Month Day Year <b>MAR. 14 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21-1884</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VIRGINIA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOHN MOORE</b>		14. MOTHER'S MAIDEN NAME <b>MARY DAUGHERTY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>ROBERT M SITES</b>	
17. INFORMANT <b>ROBERT M SITES</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>15 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1961</b> to <b>March 14, 1962</b> that (I) (we) last saw the deceased alive on <b>March 13, 1962</b> and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thos. F. Cleary MD</b>		22b. DATE SIGNED <b>3-14-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thos. F. Cleary MD</b>		22d. ADDRESS <b>5558 Silver Hill Rd Wash 28, D.C.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>3-17-62</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>EAST HILL CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>SALEM VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>DEAL FUNERAL HOME WASH. D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 19 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>W. L. Thomas</b>			



03693

CERTIFICATE OF DEATH

03690

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>6 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>6000 MILL RD. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Larry TILLMAN Smith</b>		4. DATE OF DEATH <b>March 31 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 17-35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY-DOY CLEANING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN BUSINESS</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>NASHVILLE TENN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>TILLMAN H. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES G. GIBSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>Acute Glomerulonephritis</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Polyostotic Fibrous Dysplasia of Bone</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b> <b>7 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-25-62</b> to <b>3-31-62</b> , that (I) (we) last saw the deceased alive on <b>3-31-62</b> , and that death occurred at <b>1:00 P.M.</b> the causes and on the date stated above.			
22a. SIGNATURE <b>John R. Buell</b> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <b>APR 3 '62</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE CEM.</b>		23d. LOCATION (City, town or county) (State) <b>ELK RIDGE HOWARD CO. MD.</b>	
24. SIGNATURE OF REGISTRAR <b>John R. Buell</b>		25a. REC'D BY REGISTRAR <b>APR 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>		25c. ADDRESS <b>550 WASH BLVD, LAUREL, MD.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards 1 and 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03694

03691

1 PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>11 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mitchellsville</b> d. STREET ADDRESS <b>Enterprise Road</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edward Carl Sokolowski</b>		4. DATE OF DEATH Month Day Year <b>Mar 17 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1898</b>
9. AGE (In years last birthday) <b>63</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ref. &amp; Auditor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Vet. Admin.</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Karl Sokolowski</b>		14. MOTHER'S MAIDEN NAME <b>Anna Helena Zielinski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>577-58-5836</b>	
17. INFORMANT <b>Mrs. Irene Doda Sokolowski, Wife</b>		Address <b>Above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhagic Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>2 years</b> <b>2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Hypertensive Arteriosclerotic Heart Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1957</b> to <b>3/17/1962</b> that (I) (we) last saw the deceased alive on <b>3/16/1962</b> and that death occurred at <b>12 M.</b> from the causes and on the date stated above			
22a. SIGNATURE <b>H. James Kott</b>		22b. DATE SIGNED <b>3/17/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. James Kott Jr.</b>		22d. ADDRESS <b>112 D. Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/20/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 20 '62</b>	
25b. REGISTRAR'S SIGNATURE			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. **FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR  
SM 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**03695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03692**

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b. <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b> d. STREET ADDRESS <b>6917 Varnum St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM JAMES RUDOLPH SPAHR</b>		4. DATE OF DEATH <b>March 23 19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 30, 1891</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired*Prop. Clk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>OSCAR G.E. SPAHR</b>		14. MOTHER'S MAIDEN NAME <b>MARIE GUARTZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mildred H. Spahr Same as #2</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>1 + 1 + 1 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes for last four years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/26/62</b>		22b. DATE THEREOF <b>3/26/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cent. Bladensburg, Md</b>		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Wash. D. C.</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>		DATE <b>MAR 28 '62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03696  
CERTIFICATE OF DEATH  
03693

1. PLACE OF DEATH  
e. COUNTY **PRINCE GEORGE**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **LAUREL**  
c. LENGTH OF STAY IN b. **adm 3-8-62**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **LAUREL SANITARIUM**  
2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
e. STATE **MARYLAND** b. COUNTY **Howard**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **FULTON**  
d. STREET ADDRESS **LIME KIRK ROAD**  
3. NAME OF DECEASED (Type or print) **ERLA E SPENCER**  
4. DATE OF DEATH **3 12 1962**  
5. SEX **Female** 6. COLOR OR RACE **WHITE** 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH **December 13-1876** 8. AGE (In years) **85** IF UNDER 1 YEAR IF UNDER 24 HRS.  
9. AGE (In years) **85** Months Days Hours Min  
10a. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) **housewife** 10b. KIND OF BUSINESS OR INDUSTRY **own home** 11. BIRTHPLACE (County & State, or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**  
13. FATHER'S NAME **JOHN F. STAUB** 14. MOTHER'S MAIDEN NAME **MARK BLONDER**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **none** 16. SOCIAL SECURITY NO. **none** 17. INFORMANT **Hosp. Records**  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (e)  
**Cardiac fibrillation (433.i)**  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. **myocardial degeneration with arteriosclerosis (442.i)**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
19. WAS AN AUTOPSY PERFORMED? YES ☐ NO ☒  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **3-8-62 3-12-62** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **128pm** 20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from **3-8-62** to **3-12-62** that (I) (we) last saw the deceased alive on **3-12-62** and that death occurred at **128pm** from the causes and on the date stated above.  
22a. SIGNATURE **Linda P. Kraemer** 22b. DATE SIGNED **3-12-62**  
22c. PHYSICIAN'S NAME (Type) **ERIKA P. KRAEMER** 22d. ADDRESS **LAUREL SANITARIUM, LAUREL Md.**  
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **March 15, 1962** 23c. NAME OF CEMETERY OR CREMATORY **St. Louis Cemetery** 23d. LOCATION (City, town or county) (State) **Clarksville, Howard Co., Md.**  
24. FUNERAL DIRECTOR'S SIGNATURE **Warner E. Pumphrey, Inc.** 24b. REC'D BY REGISTRAR **Raymond A. Ziden** 25b. REGISTRAR'S SIGNATURE **4434 Georgia Ave.**  
DATE **MAR 15 '62**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 1 and 2 and return them to the funeral director, page 3 should be detached for use as the burial-transit permit, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03697 CERTIFICATE OF DEATH 03694

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN (b) <u>18 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> d. STREET ADDRESS <u>4008 - 31st. Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie M. Stansbury</u>		4. DATE OF DEATH <u>March 11 1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 8, 1873</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u> Hours <u>5</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James E Withers</u>		14. MOTHER'S MAIDEN NAME <u>Priscella A Jerman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(Yes, no, or unknown)</u>		16. SOCIAL SECURITY NO. <u>(If given or date of service)</u>	
17. INFORMANT <u>Norma S Williams</u>		Address <u>Mt Rainier Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 175-0 DUE TO (b) <u>Bilateral Canc. of the ovary</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <u>heart failure</u> <u>chemic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sinus atrophy</u> <u>Arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 months</u> <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-22-62</u> to <u>3-11-62</u> , that (I) (we) last saw the deceased alive on <u>3-11-1962</u> , and that death occurred at <u>10:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leon R. Levitsky</u>		22d. ADDRESS <u>3408 Rhode Island Ave., Mt. Rainier, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 15, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D C</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 15 '62</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03698

## CERTIFICATE OF DEATH

03695

<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>23 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>DISTRICT OF COLUMBIA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOLLING AIR FORCE BASE</b> d. STREET ADDRESS <b>74 WESTOVER AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>JULIA T STROTHER</b> First Middle Last <b>5. SEX</b> <b>FEMALE</b> <b>6. COLOR OR RACE</b> <b>CAUCASIAN</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>28 SEPTEMBER 1899</b> <b>9. AGE</b> (In years last birthday) <b>62</b> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> <b>MARCH 18 1962</b> Month Day Year <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>BATESVILLE, VIRGINIA</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>UNITED STATES</b> <b>12. CITIZEN OF WHAT COUNTRY</b>	
<b>13. FATHER'S NAME</b> <b>T. W. TAYLOR</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>MARIG MOON</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b> <b>16. SOCIAL SECURITY NO</b> <b>NONE</b> <b>17. INFORMANT</b> <b>DEAN C STROTHER (HUSBAND)</b> Address <b>SAME AS ITEM #2</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>EMPHYEMA, LEFT THORAX</b> (a), stating the underlying cause last. DUE TO (c)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
<b>20. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20a. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) Hour a.m. p.m. <b>20c. INJURY OCCURRED</b> <b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>21. I certify that (I) (doctored)</b> attended the deceased from <b>23 FEBRUARY, 1962</b> to <b>18 MARCH, 1962</b> , that (I) <b>did</b> saw the deceased alive on <b>18 MARCH, 1962</b> , and that death occurred at <b>748A</b> AM, from the causes and on the date stated above. <b>22a. SIGNATURE</b> <i>Albert D Carilli</i> <b>22b. DATE SIGNED</b> <b>18 MAR 62</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>ALBERT D CARILLI, Capt USAF MC</b> <b>22d. ADDRESS</b> <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>3-21-62</b> <b>23b. DATE THEREOF</b> <b>ARLINGTON NATL</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>FT MYER</b> <b>23d. LOCATION (City, town or county)</b> <b>VA</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>W.W. Chambers G</i> <b>3072-17 St NW</b> <b>DATE</b> <b>MAR 21 '62</b> <i>James E. Evans</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carefully. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03696

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Ranier</u> d. STREET ADDRESS <u>3717 - 34th St.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry B. Sturgis</u>				4. DATE OF DEATH <u>3 5 19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-00</u>	
9. AGE (In years last birthday) <u>61 yrs.</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector, Pr. Georges Co. Health Dept. Washington, D.C.</u>	
11. BIRTH-PLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Thomas Harry Sturgis</u>		14. MOTHER'S MAIDEN NAME <u>Maudie M. Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes - 1944-1943-1942</u>				16. SOCIAL SECURITY NO. <u>1928</u>		17. INFORMANT <u>Margaret V. Sturgis, Wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>5 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 + months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-21</u> , 19 <u>62</u> to <u>3-5</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3-5</u> , 19 <u>62</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Waldo B. Moyers</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Waldo B. Moyers</u>				22d. ADDRESS <u>3503 Perry St. Mt. Rainier Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/8/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Malley's Funeral Home, Inc.</u>				ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 12 '62</u>	
				25b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03700  
CERTIFICATE OF DEATH  
03697

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>6917 Oakridge Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Walter C. Summer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-85</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>76</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Army Officer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		13. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14. FATHER'S NAME <b>Benjamin R. Summer</b>		15. MOTHER'S MAIDEN NAME <b>Ida May Dewey</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give year or dates of service) <b>Yes WW I and II</b>		17. SOCIAL SECURITY NO. <b>Charlotte C. Summer Same as #2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Coronary Artery</b> <b>Arteriosclerosis Heart Disease</b> DUE TO (b) <b>Partial Intestinal obstruction (due to malrotation left descending colon)</b> DUE TO (c) <b>Partial Intestinal obstruction (due to malrotation left descending colon)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (th's hospital) attended the deceased from <b>Dec 1961</b> to <b>3-5</b> , 1962 that (I) (we) last saw the deceased alive on <b>3-5</b> , 1962, and that death occurred at <b>9:45</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald C. Edgren</b>		22b. DATE SIGNED <b>3-6-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD C. EDGREN</b>		22d. ADDRESS <b>35-00 East-West Highway Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 8, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24b. ADDRESS <b>Hyattsville Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>MAR 8 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Enter Signature</b>	



1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03698

1. PLACE OF DEATH  
a. COUNTY

Prince George's MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE Maryland b. COUNTY Prince George's

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cheverly

c. LENGTH OF STAY in lb

D.O.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Glen Arden Heights

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Prince George's General Hospital

d. STREET ADDRESS

1505 3rd Street

3. NAME OF DECEASED  
(Type or print)

Veda

Clara

Swann

4. DATE OF DEATH

March 10

Day

1962

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIAGE STATUS

WIDOWED

DIVORCED

8. DATE OF BIRTH

Dec. 8, 1885

9. AGE (In years last birthday)

76

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

District of Columbia

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13. FATHER'S NAME

Hans Bowdwin

14. MOTHER'S MAIDEN NAME

Annie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO

none

17. INFORMANT

William Henry Swann, same as # 2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

Cardiovascular renal disease

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING CAUSE OF DEATH ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED  
March 10, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Mar 14-1962

22c. NAME OF CEMETERY OR CREMATORY

Harmony Cem - Pr Geo Co - Md -

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

William Spangler

ADDRESS

524-8-54 NE DC

24a. REC'D BY REGISTRAR

DATE MAR 12 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Howard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other necessary, use execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit file pages 1 and 2 with a State Department of Health and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files. Pages 6 and 7 should be forwarded to the State Department of Health. Pages 8 and 9 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A18ME  
5 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03699

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town Cheverly 1 hr		c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) 23 Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		e. STREET ADDRESS 3120 Powder Mill Road	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 8, 1884	
9. AGE (in years last birthday) 77 yrs.		10. FUND YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) 77 yrs.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME House wife At Home		14. MOTHER'S MAIDEN NAME Penna	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Thomas Coons		16. SOCIAL SECURITY NO. Mary Bender	
17. INFORMANT B		Address Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 782.0 DUE TO (b) Fracture of right hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 3/4/68		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor getting out of bed	
23. INJURY OCCURRED 24a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 24b. (City or town) (County) (State)		24c. (City or town) (County) (State)	
25. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		26. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
27. ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		28. DATE SIGNED 3/26/62	
29. BURIAL, CREMATION REMOVAL (Specify) Burial		30. DATE THEREOF 3/30/62	
31. NAME OF CEMETERY OR CREMATORY St. Patricks		32. LOCATION (City, town, or country) (State) Adelphi P. G. Md	
33. FUNERAL DIRECTOR Nalleys Funeral Home, Inc.		34. REC'D BY REGISTRAR 35. REG STRA'S SIGNATURE Arthur S. Kline	
36. ADDRESS (Street city town or county) Mt. Rainier Maryland		37. DATE MAR 30 '62	

MEDICAL CERTIFICATION





1  
FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03703

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03700

1. PLACE OF DEATH  
a. COUNTY

Prince George's MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Hillcrest Heights

c. LENGTH OF STAY IN lb  
19 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2915 Fairlawn Street

3. NAME OF DECEASED  
(Type or print)

Basil

Robinson

Taylor

SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Sep. 29, 1899

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

62 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Norman Billieter Taylor

14. MOTHER'S MAIDEN NAME

Flora Towers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

212-03-0729

17. INFORMANT

Charles Norman Taylor, Eastern, Md.

Address

620 South St  
on  
Eastern, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

425-1 DUE TO

(b)

DUE TO

(c)

Acute congestive heart failure

Coronary artery disease

Cardiovascular renal disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18.)

20c. TIME OF INJURY

Hour a.m.  
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address Street city town, or county

DATE SIGNED

March 31, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/3/62

22c. NAME OF CEMETERY OR CREMATORY

Junior Order Cemetery

ADDRESS

22d. LOCATION (City, town, or country)

preston, Maryland

(State)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE APR 3 '62

Charles S. Pears

23. FUNERAL DIRECTOR

W. Hampton Carroll  
W. Hampton Carroll

Easton, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any case execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 and retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

03704

03701

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cottage City</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4005 Bunker Hill Rd</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>M.</b> Last <b>Tayman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1883</b>		9. AGE (In years last birthday) yrs <b>78</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Smith</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wells</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>		17. INFORMANT Address <b>Same as Mrs. Mabel Elizabeth Thornburg- Item 1.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>3 + 4 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 + 4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-24</b> , 19 <b>59</b> , to <b>3-25</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>3-24</b> , 19 <b>62</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Perry St., Mt. Rainier, Maryland.</b> DATE SIGNED <b>3/25/62</b>							
ACTUAL SIGNATURE <b>Waldo B. Moyers</b>		M.D. <b>Waldo B. Moyers, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Croom, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				ADDRESS <b>Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Apr 3 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. W. S. Hume</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03705 CERTIFICATE OF DEATH 03702

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Clinton c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Southern Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS Rt. 2 Box 179		e. 15. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francis Cleaverson Thompson First Middle Last 4. DATE OF DEATH March 12 1962 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 3 1888 9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY SELF 11. BIRTHPLACE (County & State, or foreign country) Prince George - Md - America 12. CITIZEN OF WHAT COUNTRY			
13. FATHER'S NAME PLIM THOMPSON 15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO YES 17. INFORMANT IRENE M THOMPSON WALDORF, MD. Address		14. MOTHER'S MAIDEN NAME ANNIE JOHNSON		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO (b) Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertensive Heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from... 1-1-1962 to 3/12/1962, that (I) (we) last saw the deceased alive on... 3-12-1962, and that death occurred at 2 P.M. from the causes and on the date stated above. 22a. SIGNATURE James M. Fadeley M.D. 22c. PHYSICIAN'S NAME (Type) JAMES M. FADELEY 22b. DATE SIGNED 22d. ADDRESS CLINTON MD 22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-15-62		23c. NAME OF CEMETERY OR CREMATORY ST BARNABAS CHURCH CEMETERY		23d. LOCATION (City, town or county) OXEN HILL, MD. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W W Chambers & Son		ADDRESS WASH, D.C. 517-1114 St. J.B.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. JUNE 1962  
JUNIOR DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03706  
03703

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN b 1 month and 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5048 8th St., N.E.											
3. NAME OF DECEASED (Type or print) First Middle Last Mary Thompson 4. DATE OF DEATH Month Day Year 3 22 19 62				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/14/14		9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) S. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ketto Wright				14. MOTHER'S MAIDEN NAME Amelia Butler Wright				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Decedent				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). Cor pulmonale 021 DUE TO Conditions, if any, which gave rise to immediate cause (b). pulmonary tuberculosis (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Tuberculous empyema, left; left pleuro-cutaneous fistula; left thoracoplasty; diabetes mellitus; urinary infection, etiology undetermined.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 2/21/1962 to 3/22/1962, that (I) (we) last saw the deceased alive on 3/22/1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE 3/22/62				22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-26-62				23c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR DATE MAR 27 '62				25b. REGISTRAR'S SIGNATURE							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)  
15M 9/60

(M)

(I)

2

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03707											
03704											
1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>US AIR FORCE HOSPITAL ANDREWS</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HILLSIDE</b> d. STREET ADDRESS <b>5501 "O" STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>JEANNETTE AGNES</b>						4. DATE OF DEATH Last First Middle <b>19 62</b> Day Month Year <b>MARCH 19 19 62</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>24 FEBRUARY 1894</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>PHILIP HADEN</b>						14. MOTHER'S MAIDEN NAME <b>Jones</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT Address <b>Wm. J. Tierney Sr 5501-O-St. Hillside, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>3</b> <b>1</b> <b>X</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) <b>cerebral hemorrhage</b> <b>hypertensive vascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>18 MARCH 19 62</b>		20g. (County) <b>19 MARCH 19 62</b>		20h. (State) <b>XX</b>	
21. I certify that (i) <del>XXXXXX</del> attended the deceased from <b>18 MARCH</b> to <b>19 MARCH</b> , 19 <b>62</b> , that (i) <b>XX</b> last saw the deceased alive on <b>19 MARCH</b> , 19 <b>62</b> , and that death occurred at <b>1240P</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Albert D Carilli</b>						22b. DATE SIGNED <b>19 MAR 62</b>					
22c. PHYSICIAN'S NAME (Type) <b>ALBERT D CARILLI, Capt USAF MC</b>						22d. ADDRESS <b>USAF HOSP, ANDREWS AIR FORCE BASE, MD</b>					
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial March 21-62</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City town or county) <b>Southland 2nd</b>		23e. REC'D BY REGISTRAR <b>MAR 21 '62</b>		23f. REGISTRAR'S SIGNATURE <b>William L. Frawley</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sammons Bros</b>						24b. ADDRESS <b>1641-40 Hope Rd S Wash DC</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03708

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03705

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

### 1. PLACE OF DEATH

a. COUNTY

Prince George's

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

c. LENGTH OF STAY IN 1b

1 1/2 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4904 43rd Street

3. NAME OF DECEASED  
(Type or print)

JOHN

GLENN

TIPPETT

5. SEX

Male

White

7. MARRIED

NEVER MARRIED ☒

8. DATE OF BIRTH

Aug. 28, 1945

9. AGE (In years last birthday)

16 yrs.

IF UNDER 1 YEAR

Months Days Hours M n.

a. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

4. DATE OF DEATH

March 25

19 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Short Order Cook

10b. KIND OF BUSINESS OR INDUSTRY

Food

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Arthur Tippet

14. MOTHER'S MAIDEN NAME

Bessie Agnes Cook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

Address

John Arthur Tippet, Same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Hemorrhage and shock

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Gun shot wound in the chest

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Shot self in the chest with a 22 Cal. rifle

20c. TIME OF INJURY Month, Day, Year

7:30 PM 3/25 62

20d. INJURY OCCURRED

While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Home

20f. (City or town)

Hyattsville P.G., Md.

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

James I. Boyd

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

3/25/62

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/28/62

22c. NAME OF CEMETERY OR CREMATORY

Washington National

22d. LOCATION (City, town, or county)

Suitland, Maryland

(State)

23. FUNERAL DIRECTOR

Francis Gasch's Sons

ADDRESS

Hyattsville, Md.

24a. REC'D BY REGISTRAR

MAR 29 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Hanna



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03709

03706

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

<b>1. PLACE OF DEATH</b> a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN b 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE D.C. b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1390 Rittenhouse St. NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) Simon - Troshinsky First Middle Last <b>5. SEX</b> Male <b>6. COLOR OR RACE</b> White <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> 1908 <b>9. AGE</b> (In years last b 1 day) 74 yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.		<b>4. DATE OF DEATH</b> 3 29 19 62 <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Retired (Sexton) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> - <b>11. BIRTHPLACE</b> (County & State, or foreign country) Poland <b>12. CITIZEN OF WHAT COUNTRY?</b> Poland	
<b>13. FATHER'S NAME</b> Hillel Troshinsky <b>14. MOTHER'S MAIDEN NAME</b> Esther		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) - <b>16. SOCIAL SECURITY NO.</b> 579-50-9996 <b>17. INFORMANT</b> Mrs. DORA Papier Indian Head, Md. 400 Indian Head Ave.	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebrovascular accident with right hemiparesis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary tuberculosis; generalized arteriosclerosis; hypertensive cardiovascular disease (historical)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20c. TIME OF INJURY</b> Month, Day, Year 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from 3/26/1962 to 3/27/1962 that (I) (we) last saw the deceased alive on 3/29/1962 and that death occurred at 11 A.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> Moe Weiss, M.D. <b>22b. DATE SIGNED</b> 3/29/62		<b>22c. PHYSICIAN'S NAME (Type)</b> Moe Weiss, M.D. <b>22d. ADDRESS</b> Glenn Dale Hospital Glenn Dale, Md.	
<b>23a. BURIAL OR CREMATION</b> BURIAL <b>23b. DATE THEREOF</b> March 28, 1962 <b>23c. NAME OF CEMETERY OR CREMATORY</b> NATIONAL CAPITAL-HEBREW CEM. Washington D.C.		<b>23d. LOCATION</b> (City, town or county) (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> B. Danzansky <b>25a. REC'D BY REGISTRAR</b> DATE MAR 30 '62 <b>25b. REGISTRAR'S SIGNATURE</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and place them in the envelope provided. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03710

## CERTIFICATE OF DEATH

03707

<b>1. PLACE OF DEATH</b> COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine Md.</u> c. LENGTH OF STAY IN b. <u>1</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>P.R. Geo Co</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine, Maryland</u> d. STREET ADDRESS <u>Rt. 1, Box 356</u>											
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>3. NAME OF DECEASED</b> (Type or print) <u>Clarence L. Tucker</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 8, 1884</u>									
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Rail Road</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Plummer Tucker</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Cornelia Downs</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>									
<b>16. SOCIAL SECURITY NO.</b> <u>215-35-6684</u>		<b>17. INFORMANT</b> <u>Fannie T. Tucker</u>		<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>Same as #2</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lanette's cirrhosis + massive ascites + anasarca</u>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. 19 p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>Dec 2, 1961</u> <b>to</b> <u>March 5, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>March 3, 1962</u> <b>and that death occurred at</b> <u>7:30 P.M.</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Alfred R. Lapin</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ALFRED R. LAPIN</u>				<b>22d. ADDRESS</b> <u>CLINTON, MARYLAND</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>March 5-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Pauls</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>Bader, Maryland</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Simmons Bros</u>				<b>25a. REC'D BY REGISTRAR</b> <u>5 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03711  
CERTIFICATE OF DEATH  
03708

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> LENGTH OF STAY IN <u>3 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakcrest, Laurel</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Engle Island Memorial Hosp</u>		d. STREET ADDRESS <u>214 Linden Street</u>	
3. NAME OF DECEASED (Type or print) <u>Mamie Virginia Tucker</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1916</u> <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Ross</u>		14. MOTHER'S MAIDEN NAME <u>Lily Palk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT <u>Mr. Norman Tucker, Laurel, Md.</u>		Address <u>214 Linden St</u>	
18. CAUSE OF DEATH [Enter only one cause and line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>287X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (e), stating the underlying cause last. (c) <u>Obesity - Worry</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 yr</u> <u>15 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> , 19 <u>60</u> , to <u>3/9</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>62</u> ; and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>B P Warren</u> M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>B P WARREN</u>		22d. ADDRESS <u>Laurel</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/12/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>		23d. LOCATION (City, town or county) <u>Sanage, Md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>		25a. RECEIVED BY REGISTRAR <u>Laurel, Md</u> DATE <u>MAR 13 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03712

## CERTIFICATE OF DEATH

03709

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 636 I. St., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida 4. DATE OF DEATH 3 15 19 62 5. SEX Female 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/1/1890 9. AGE (In years last birthday) 71 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Dincee Cheselton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Betty Williamson		14. MOTHER'S MAIDEN NAME Henerietta Cheselton Address 5129 Fisher Rd., Temple Hills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease with cardiac decompensation DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Chronic pyelonephritis, epigastric mass, etiology undetermined, diabetes mellitus, gastrointestinal bleeding, etiology undetermined. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH Unknown	
21. I certify that (I) (this hospital) attended the deceased from 2/16/1962 to 3/15/1962, that (I) (we) last saw the deceased alive on 3/15/1962, and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22b. DATE SIGNED 3/15/62 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Mar 19-62 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) Smithland, Maryland		25a. REC'D BY REGISTRAR 1661 Good Hope Rd. S.E. Wash. D. C. DATE MAR 19 '62 25b. REGISTRAR'S SIGNATURE J. Edgar L. Thomas	
24. FUNERAL DIRECTOR'S SIGNATURE Sammons Funeral Home			



CERTIFICATE OF DEATH

Reg. Dist. No. 03710

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Madison Manor Nursing Home</u>		d. STREET ADDRESS <u>6301 Kansas Ave., N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>SAVERIO VAGNERINI</u>		4. DATE OF DEATH <u>MARCH 26</u> 19 <u>62</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
13. FATHER'S NAME <u>Michael Vagnerini</u>		14. MOTHER'S MAIDEN NAME <u>Rose Coscini</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-01-4819</u>	
17. INFORMANT <u>Mae C Vagnerini</u>		Address <u>came as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> DUE TO <u>ISK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>3-1-62</u> , 19 <u>62</u> , to <u>3-26</u> , 19 <u>62</u> that I last saw the deceased alive on <u>3-26-62</u> , 19 <u>62</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Clum</u>		DATE SIGNED <u>3-26-62</u>	
PHYSICIAN'S NAME (Type) <u>John P. Clum</u>		ADDRESS (Street, city or town, state) <u>6110 43rd Ave Hyattsville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-30-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee</u>		24a. REC'D BY REGISTRAR <u>300 Hth St. N.E.</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>MAR 28 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, and in any event, within 72 hours after death, be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

1  
03714  
03711

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

Item 3 Film 0311 4/23/62

1. PLACE OF DEATH  
a. COUNTY **PRINCE GEORGES** b. CITY OR TOWN **ANDREWS AIR FORCE BASE** c. LENGTH OF STAY IN 1b **MARYLAND**  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **US AIR FORCE HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE **MARYLAND** b. COUNTY **PRINCE GEORGES**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, **HILLCREST HEIGHTS**  
d. STREET ADDRESS **5916 SAINT CLAIR STREET**

3. NAME OF DECEASED (Type or print) **JOSEPH** First **Henry** Middle **WALSH** Last **WALSH**  
4. DATE OF DEATH **MARCH 29 19 62**

5. SEX **MALE** 6. COLOR OR RACE **CAUCASIAN** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **10 NOVEMBER 1907** 9. AGE (In years last birthday) **54** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **US AIR FORCE** 10b. KIND OF BUSINESS OR INDUSTRY **US AIR FORCE** 11. BIRTHPLACE (County & State, or foreign country) **BALTIMORE, MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **UNITED STATES**

13. FATHER'S NAME **JOSEPH WALSH** 14. MOTHER'S MAIDEN NAME **JUSKAUSKAS**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **YES** (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. **554-10-3624** 17. INFORMANT Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **SUBARACHNOID HEMORRHAGE**  
330 X } DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) **CEREBRAL ARTERIOSCLEROSIS**  
(c) **HYPERTENSION**

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) ~~XXXXXX~~ attended the deceased from **28 MARCH 1962** to **29 MARCH 1962** that (I) ~~XXXX~~ last saw the deceased alive on **29 MARCH 1962**, and that death occurred at **11:50 A.M.** from the causes and on the date stated above.

22a. SIGNATURE **Emanuel Milder** M.D. 22b. DATE SIGNED **29 MARCH 1962**  
22c. PHYSICIAN'S NAME (Type) **EMANUEL MILDER, Capt USAF MC** 22d. ADDRESS **USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **April 2-62** 23c. NAME OF CEMETERY OR CREMATORY **Arlington National** 23d. LOCATION (City, town or county) (State) **Arlington Virginia**

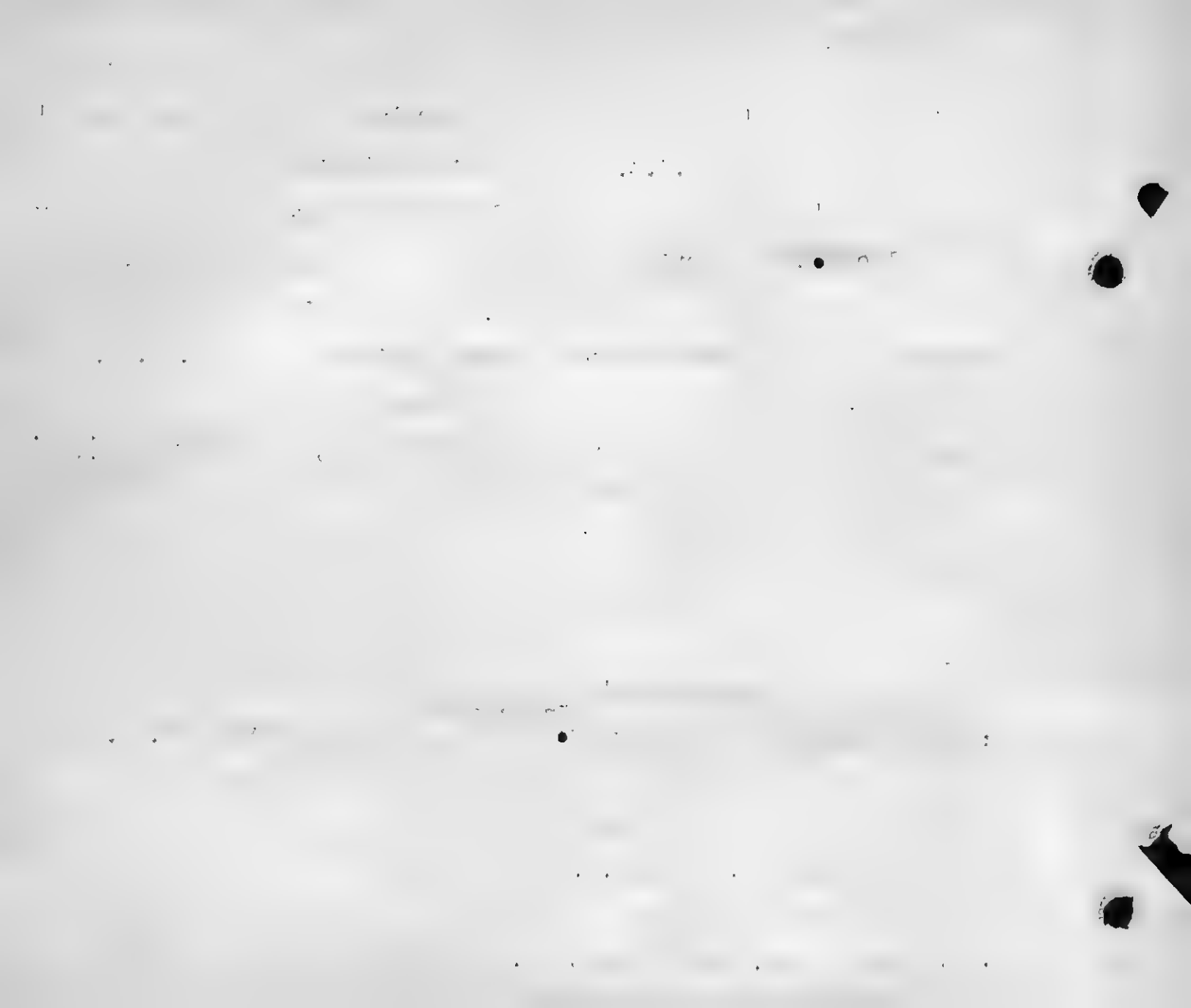
24. FUNERAL DIRECTOR'S SIGNATURE **Sumner Bros 1661-94 Hope Rd. S.E. Wash DC** 25a. REC'D BY REGISTRAR **DATE APR 2 '62** 25b. REGISTRAR'S SIGNATURE **Charles S. Frank**





VR A15ME  
5M 1/62

## MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur-ol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03715

03713

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bellmeade, Md</b>		c. LENGTH OF STAY IN 1b <b>7</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bellmeade, Md.</b>		d. STREET ADDRESS <b>7411 Allison Street,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>7411 Allison Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Antone</b> Middle <b>A.</b> Last <b>Wenzl</b>		4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 62.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1885</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min. <b>62.</b>	IF UNDER 24 HRS Months <b>7</b> Days <b>13</b> Hours <b>19</b> Min. <b>62.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Gardner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Homes</b>	11. BIRTHPLACE (State or foreign country) <b>Asturiadia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Jacob Wenzl</b>	
14. MOTHER'S MAIDEN NAME <b>Marie Martinek</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>578-36-0382</b>		17. INFORMANT <b>Marie Wenzl Same as #2 (Wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>154X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 yrs</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1951</b> to <b>3/13 1962</b> that (I) <del>was</del> last saw the deceased alive on <b>3/13 1962</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr Frederick Musser</b> M.D.		22b. DATE SIGNED <b>3/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr Frederick Musser</b>		22d. ADDRESS <b>Bellmeade, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 16, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>MAR 19 '62</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



V5. AISME  
5M 9/60

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b>		c. LENGTH OF STAY IN ID <b>Transient</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In a wooded area near Groes Road</b>		d. STREET ADDRESS <b>Route # 3, Box 74</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William</b>		First Middle Last <b>West</b>		4. DATE OF DEATH Month Day Year <b>March 6 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1892</b>	9. AGE (in years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Daniel T. West</b>		14. MOTHER'S MAIDEN NAME <b>Martha Pinkney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>000-45-6789</b>		17. INFORMANT Address <b>Turner West, Box 129, Route # 2 Brandywine, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>922-2-2 Exposure to cold</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Exposed to cold during snow storm.</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>March 5, 1962</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cross Road</b>	
		20f. (City or town) <b>Cheltenham, Md.</b>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>3/6/62</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		Address (Street, city, town, or county) <b>ARLINGTON CEM. ARLINGTON, VA.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3-9-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON CEM.</b>		22d. LOCATION (City, town, or country) (State) <b>ARLINGTON, VA.</b>	
23. FUNERAL DIRECTOR <b>HUNT FUNERAL HOME, WILMINGTON, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 12 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>	



03718

## CERTIFICATE OF DEATH

03715

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b. <b>10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>4400 Tuckerman Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Albert</b>		First <b>Paul</b>		Middle <b>Wheatley</b>	
4. DATE OF DEATH <b>March 31 19 62</b>		Month <b>March</b>		Day <b>31</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <b>18 August 1913</b>		9. AGE (In years last birthday) <b>48 4/9</b>		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trial Examiner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (Country & State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>H. Winship Wheatley</b>		14. MOTHER'S MAIDEN NAME <b>Emma Kehoe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Frances Jackson Wheatley Same as #2 (Wife)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <b>Myocardial Infarction secondary to occlusion of the right coronary artery.</b> DUE TO <b>Coronary arteriosclerotic heart disease</b> DUE TO DUE TO		19. WAS AUTOPSY PERFORMED? <b>YES</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Massive intestinal hemorrhage secondary to idiopathic thrombocytopenia</b>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While Not While of work of work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hyattsville, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-21-62</b> to <b>3-31-62</b> , that (I) (we) last saw the deceased alive on <b>3-21-62</b> and that death occurred on <b>3-31-62</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Dr. A. Deltz., M.D.</b>		22b. DATE SIGNED <b>3-31-62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/3/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City, town or county) <b>Colmar Manor, Md.</b>		23e. REC'D BY REGISTRAR <b>APR 3 '62</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Health, Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15M 9/60

15M 9/60



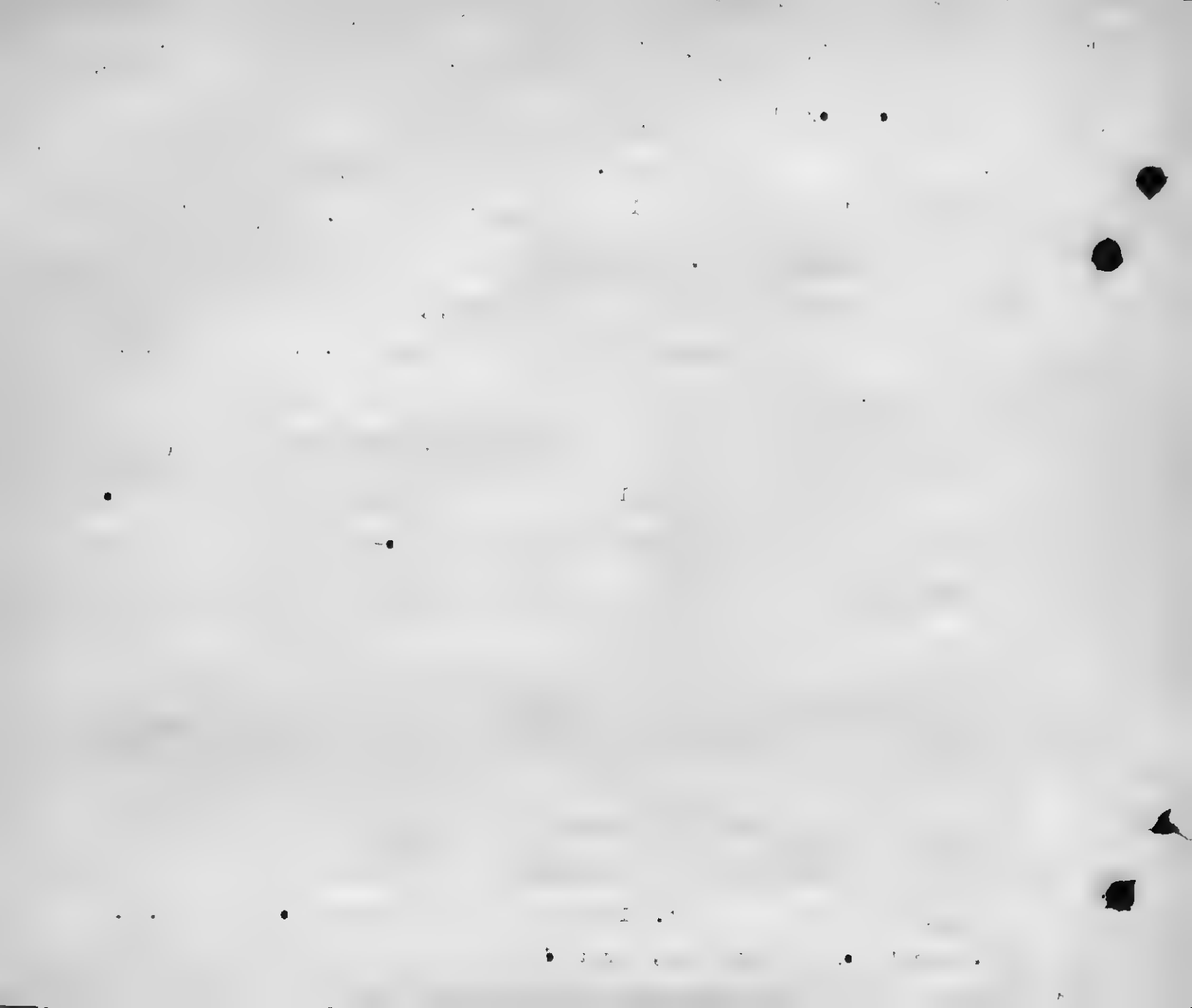


VS. A15ME  
5M 9 60

DATE MAR 13 '62

F. Gasch's Sons Hysttsville, Maryland

1147







1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03721  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03718

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Camp Springs	
c. LENGTH OF STAY in lb 1 year		d. STREET ADDRESS 6784 Allentown Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6784 Allentown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Truman Wilson		4. DATE OF DEATH March 2 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1958 3
9. AGE (In years last birthday) 6 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Earl Truman Wilson		14. MOTHER'S MAIDEN NAME Myrtle Virginia Brock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Myrtle Virginia Wilson, same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (b) UNiversal burnæ of the body (c) DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Occupant of a house that burned down	
20c. TIME OF INJURY Hour XX 2:27 PM Month, Day Year 3/2 19 62		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home Camp Springs P. G. Md	
21. I certify that I took charge of the remains described above, he d an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 3-5-1962		DATE SIGNED 3/2/62	
22c. NAME OF CEMETERY OR CREMATORY WASH NATIONAL		Address (Street, city, town, or county) SUITLAND MD	
23. FUNERAL DIRECTOR VW CHAMBERS Co		24. REC'D BY REGISTRAR MAR 7 '62	
24b. REGISTRAR'S SIGNATURE Arving S. Krause			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, it should be executed by the funeral director, if one is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Camp Springs</b>	
c. LENGTH OF STAY IN 1b <b>1 year</b>		d. STREET ADDRESS <b>6784 Allentown Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6784 Allentown Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <b>Karen Edith Wilson</b> (Type or print)		4. DATE OF DEATH <b>March 2 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1960</b>
9. AGE (In years last birthday) <b>2 yrs.</b>		10. IF UNDER 1 YEAR <b>2</b> <b>19</b> <b>62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Earl Truman Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Virginia Bock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Myrtle Virginia Wilson, same as # 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Universal burns of the body</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of a house that burned down</b>	
20c. TIME OF INJURY <b>2:27 p.m.</b> <b>3/2</b> <b>19 62</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20e. CITY OR TOWN <b>Camp Springs P. G. Md</b>		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-5-1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WASH NATIONAL SUTLAND</b>		22d. LOCATION (City, town, or country) (State) <b>MD</b>	
23. FUNERAL DIRECTOR <b>WW CHAMBERS CO</b>		24a. REC'D BY REGISTRAR <b>7 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Conroy S. Thomas</b>			





MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03723

03720

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <b>Raymond Baker Windsor</b> Middle Last				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1962</b> 19			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31 1882</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Windsor</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217 36 7331</b>		17. INFORMANT <b>Blanche O. Windsor, Clinton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>Cardiovascular renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>March 5, 1962</b> that (I) (we) last saw the deceased alive on <b>March 5, 1962</b> and that death occurred at <b>9:00</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>James I. Boyd</b> M. D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>James I. Boyd</b>				22d. ADDRESS <b>8200 Marlboro Pike S.E. Washington 28, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>March 10 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Piscataway, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home</b>				25a. REC'D BY REGISTRAR <b>MAR 12 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. ...</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03724

03721

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville - Adelphi c. LENGTH OF STAY N 1b 1 yr. 4 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Saint Branch Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3804 JUNIPER ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David Earl First Middle 4. SEX Male 5. COLOR OR RACE White 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 23, 1893 9. AGE (in years last birthday) 69 yrs. 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Pharmacist 10b. KIND OF BUSINESS OR INDUSTRY Drug Fair 11. BIRTHPLACE (County & State or foreign country) Hagerstown, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Elmer Wolf 15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 17. INFORMANT Address Nursing Home Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure +20.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial Infarction (c) Arteriosclerotic Heart Disease DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Gastrointestinal Hemorrhage, Cerebral Vascular Accident	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1962 to March 31, 1962, that (I) (we) last saw the deceased alive on March 28, 1962, and that death occurred at . . . M, from the causes and on the date stated above.			
22a. SIGNATURE Stuart L. Nelson 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4-3-62		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Unknown		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE 2 '62	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the physician and coroner's offices must be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The coroner's office must be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03725  
CERTIFICATE OF DEATH  
03722

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5621 Hamilton Manor Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Adrian P. Wolff</b>		4. DATE OF DEATH Month Day Year <b>March 20 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-29-1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TYPIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LUCIEN F. WOLFF</b>		14. MOTHER'S MAIDEN NAME <b>GEORGIANNA MURPHY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-01-6357</b>	
17. INFORMANT <b>HOSPITAL RECORDS - 1-D.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction,</b> DUE TO <b>Arteriosclerotic Heart Disease,</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Cerebral Vascular Accident.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 <b>3/20</b> , to <b>3/20</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>3-20</b> , 19 <b>62</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Leon L. Gallin</b> M.D.		22b. DATE SIGNED <b>3/20</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon L. Gallin</b>		22d. ADDRESS <b>7206 Colesville Rd., West Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/23/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	23d. LOCATION (City, town or county) (State) <b>WHEATON Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Naulon - 4748 - N. Ave. Dr.</b>		25. REC'D BY REGISTRAR <b>MAR 27 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03726 CERTIFICATE OF DEATH 03723

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 22 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's Gen. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North Forestville d. STREET ADDRESS 3425 84th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linda Marie Wright First Middle Last		4. DATE OF DEATH March 3 4 19 62 Date Month Day Year		5. AGE (In years last birthday) 22 If UNDER 1 YEAR: Months Days Hours Min. If UNDER 24 HRS: Hours Min.	
6. SEX Female		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md	
13. FATHER'S NAME Vernon Dyson Wright		14. MOTHER'S MAIDEN NAME Mary Eileen Richardson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mother Same as above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature birth; B.W. illness 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Prince George's		20g. (County) Prince George's		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from March 3, 1962, to March 4, 1962, that (I) (we) last saw the deceased alive on March 4, 1962, and that death occurred at 6:50 PM from the causes and on the date stated above					
22a. SIGNATURE Dr. J. A. Samsa		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. J. A. Samsa	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-17-62		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr., Administrator		24a. ADDRESS		25a. REC'D BY REGISTRAR MAR 21 '62	
25b. REGISTRAR'S SIGNATURE		25c. LOCATION (City, town or county) (State)		25d. REGISTRAR'S SIGNATURE	

2-27845





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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03724

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillcrest Heights</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>2120 Gaither Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2120 Gaither Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Lee Wyche</b>		4. DATE OF DEATH Month Day Year <b>March 26th., 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1918</b>
9. AGE (In years last birthday) <b>44</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Book Binder</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Howard Bernard Wyche</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Lee Rakestraw</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes NW 11</b>		16. SOCIAL SECURITY NO. <b>578-05-4779</b>	
17. INFORMANT <b>Leona Matilda Wyche</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Gun shot wound of head</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self through head</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:45 xx 3/26 19 62</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hillcrest Hgt's P.G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>3/26/62</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or country) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR <b>Lee Funeral Home - Washington D.C.</b>		24a. REC'D BY REGISTRAR <b>MAR 28 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Clarence S. Thomas</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



Prince George's

Wiltshire Heights

2150 Galtier Street

Ottawa

Male White

Book Number

Howard Bernard Wyse

Age 31

514-05-719 Leonie Kavita Wyse

Jack and

Heavenly and Book

Two short words of love

Shot with Thompson gun

4:15 PM 22

Wiltshire Heights P.O. Box

2

3150 Galtier

James I. Boyd, M.D.

10-1-1911

Wiltshire

Wiltshire Heights

2150 Galtier Street

Ottawa

Male White

Book Number

Howard Bernard Wyse

Age 31

514-05-719 Leonie Kavita Wyse

Jack and

Heavenly and Book

Two short words of love

Shot with Thompson gun

4:15 PM 22

Wiltshire Heights P.O. Box

2

3150 Galtier

James I. Boyd, M.D.

10-1-1911

08724

Wiltshire

Wiltshire Heights

2150 Galtier Street

Ottawa

Male White

Book Number

Howard Bernard Wyse

Age 31

514-05-719 Leonie Kavita Wyse

Jack and

Heavenly and Book

Two short words of love

Shot with Thompson gun

4:15 PM 22

Wiltshire Heights P.O. Box

2

3150 Galtier

James I. Boyd, M.D.

10-1-1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03728

CERTIFICATE OF DEATH

03725

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>77</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edmonston</b> d. STREET ADDRESS <b>4909 - 52nd. Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>William L. Zier</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>10</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-3-83</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U S Government</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington D C</b>
<b>13. FATHER'S NAME</b> <b>Jacob B Zier</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Ella Pierce</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>220 32 6931</b>	<b>17. INFORMANT</b> <b>Josephine B Zier</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary congestion</b> 54-5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Bronchopneumonia both side</b> DUE TO (c) <b>Recent partial gastrectomy and gastrojejunostomy</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> Month, Day, Year <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from 3-5-1962 to 3-10-1962 that (I) (we) last saw the deceased alive on 3-10-1962, and that death occurred at 6:40 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <i>Bernard F. Peacock</i>		<b>22b. ADDRESS</b> <b>4307 Branch Ave. S.E. Wash 21</b>	<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Bernard F. Peacock</b>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>3/13/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ceder Hill Cemetery</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>		<b>24b. ADDRESS</b> <b>Hyattsville, Maryland</b>	<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 '62</b>
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>		<b>26. DATE SIGNED</b> <b>3/12/62</b>	

(M)

1952

1952

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]

Order Bill Number: [illegible]